

THE SCHOOL OF NURSING

The School of Nursing has an enrollment today of 388 three-year Massachusetts General Hospital students, 13 Radcliffe-Massachusetts General Hospital Coordinated Program students, 24 students affiliating from Simmons College, and 24 men and women coming from McLean, a total of 449. All of these students receive instruction at the School of Nursing and so use the class room facilities provided for the Massachusetts General Hospital School.

Because of their varying educational backgrounds, each group of students must be taught separately. In order to avoid upset to the wards, where the students have their clinical experience, the various classes and groups of students are divided into sections: the Massachusetts General Hospital first year students into 8 sections; second year into 5 sections; third year into 7 sections. When other groups are also divided there are 22 different groups for which class rooms must be planned.

Unlike schools in general education, the calendar for the School of Nursing is spread over 12 months. Vacations may occur at any time during the year, but the class schedule is continuous except for one week at Christmas, and a few days at the end of each quarter.

In a week with an average schedule, December 14, there are 201 different classes, conferences, or laboratory sections. To accommodate these classes today the School has full use of:

- two class rooms in Walcott House basement, both below street level so that dirt blows in constantly; ventilation difficult, lighting poor.

- one class room in Phillips House basement. Hot pipes run under floor making heat intolerable in warm weather.

- one small conference room in Thayer on the first floor. On Charles Street side, and noise from street extremely difficult when windows are open.

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one nursing laboratory in Thayer basement, built in 1880's. Deep below street, small inadequate windows for ventilation. Dirt blows in constantly even though windows are shut.

two nursing laboratories in the Domestic Building. Too small to allow students both to work at beds and permit class to sit down at end of session for discussion period.

one diet laboratory in Thayer.

two science laboratories in the Domestic Building. Chemistry laboratory entered through anatomy and physiology laboratory. Disturbs class unless scheduled simultaneously.

one class room at 20 Charles Street - satisfactory but usable only by Freshmen. Two more hoped for when building code restrictions are removed or met.

The School shares with medical and other groups the upper and lower Out-Patient Department amphitheatres.

Classes which cannot be planned for in the above rooms are scheduled in the residence living rooms and bean parlors, instructors' sitting room, and offices and ward solarium. With the consent of the Chiefs of Staff in Gynecology, Pediatrics, Medicine and Surgery, their respective conference rooms and amphitheatre may be used if not already engaged, a helpful but tenuous facility upon which to depend.

The class room situation has steadily worsened as buildings have been reconstructed to meet growing demands for space for all groups. The class room on Baker Memorial 12 was lost when the Warren Building was constructed. The class room on Bulfinch 4 was taken for a medical laboratory. Five office-conference rooms in the White Building were absorbed for other uses. Plans for future buildings show the replacement of Thayer and the Domestic Building, which will make the situation of the School impossible unless other facilities can be provided.

the main laboratory in the basement, built in 1930. The
below street, small laboratory with the ventilation, and
there is completely new through window and door.
The main laboratory is the basement building. The main
laboratory is built in 1930 and is built above the main
and of section for laboratory work.

one that laboratory is known.

Two rooms in the basement building. Laboratory
laboratory appears through window and door, and laboratory.
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The future development of the School is vital to the Hospital's program. From the graduates of the School comes the core of the Hospital's Nursing Service. The Senior Class, because the nurse internship is provided in the third year, adds nursing services equivalent to 90 graduate staff nurses.

True, the School's program may change in the future, but these changes will not remove or reduce the need for class room, laboratory, library, or office facilities. Student nurses must be taught while they are learning to nurse, and the three-year Massachusetts General Hospital School must surely continue in the foreseeable future if Massachusetts General Hospital nursing needs are to be met.

The School should have a separate school building sufficient in size to provide the following:

- a. a lecture room, seating capacity 175.
With provisions for the use of modern audio-visual aids.
- b. a demonstration room, seating capacity 80. This room should provide facilities for bed and other equipment necessary for nursing demonstrations, with provisions for the use of modern audio-visual aids.
- c. 4 nursing laboratories
 - 1 seating 24 with space for 6-9 beds
 - 3 seating 35-40 each with space for 15 beds all to have a platform large enough to accommodate bed, bedside equipment, and a teacher demonstrator.
- d. 2 science laboratories for anatomy and microbiology, seating 40.
 - 1 science laboratory for chemistry, seating 40.
 - 1 nutrition laboratory, or if possible to be combined with the chemistry laboratory.
- e. 1 large class room, seating 80.
With provisions for the use of modern audio-visual aids.
- f. 10 small class rooms each seating 40
With provisions for the use of modern audio-visual aids.

- g. 20 conference and seminar rooms, each seating 20, some with space for audio-visual aid equipment
- h. Library, seating 150-175
Also with office work space for librarian, storage space for magazines and books not at the moment ready for or desired in the stacks, and ample stacks and pamphlet files for a growing library.
- i. record room for permanent school records.
- j. office space for 55 teachers and 6 secretaries.
- k. school health service, preferably in new Clinics Building.
- l. coat room for student's coats and lockers for 180 commuters.
- m. student lounge to seat 30-40.
- n. faculty lounge to accommodate 12.
- o. faculty conferences room to accommodate 25.
- p. storage space for audio-visual aids.
- q. 3-4 wash rooms (1 for men).

R.S.TD
1-5-60

1. The Committee has received reports from various sources that the Government is planning to launch a large-scale campaign of repression against the people of the country.

2. It is requested that the Government should take immediate steps to prevent such a campaign and should ensure that the people are free to express their views without any fear of repression.

3. The Committee also wishes to express its deep concern over the situation in the country and its hope that the Government will take prompt action to rectify the situation.

4. It is further requested that the Government should ensure that the people are fully informed of the situation and that they are given an opportunity to express their views.

5. The Committee wishes to express its appreciation to the Government for its efforts to improve the situation in the country and its hope that it will continue to work for the betterment of the people.

6. It is also requested that the Government should ensure that the people are given the opportunity to elect their representatives to the National Assembly.

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ADDRESS

by

RUTH SLEEPER

DEPARTMENT OF DIPLOMA PROGRAMS

NEW JERSEY LEAGUE FOR NURSING

January 27, 1960

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
125 WEST 47TH STREET
NEW YORK 19
DESCRIPTIVE RECORD

WHO SHALL SAY?

At least five times in the last several years I have been asked to speak on the three-year school of nursing. Sometimes I was asked to point my remarks toward its relationship to the degree program, once it was indicated a defense of the traditional pattern of control might be emphasized. Again the emphasis was to be placed on patient care. All obviously were to be statements in support of the three-year, hospital-controlled, diploma-granting school of nursing.

The time has come, I believe, when the hospital-controlled school needs no defender. It is here. It furnishes a major and desperately needed share of the country's supply of nurses. That is a fact in our society today, and we as nurses above all people should wish to see this supply continue to fill the need.

Let me re-emphasize here, lest I be misunderstood. I am for the best in nursing education. I am for the diploma program. I am for the baccalaureate degree program. I am for the junior college school of nursing. I am for the school for practical nurse training. In short, I am for nursing education.

I have only one voice. It can well be said that I am prejudiced. If I am truthful I should say that I am prejudiced. My prejudice is, in my opinion, the result of careful observation and study. As a director of a nursing service also, I have many opportunities first hand to hear other voices too. So my decision is not based alone on my personal thinking or feeling.

Who shall say how nurses are to be educated? Should we listen to the consumer, the patient, the family? If you were the patient, whose care would you choose to have? Would you choose an aide to help with the acts of

daily living for one too weak, too handicapped physically or emotionally, to carry on alone? Sometimes yes; often, very often, no. If you were the sick patient in a ward would you feel secure; could you lay aside the worry—to rest? Would it make a difference if the only nurse hurried between two wards all night giving the injections, but passing you by because none were ordered for you? Would the frightening shortness of breath ease so you could sleep? What of tomorrow's operation? Will the aide know how to keep the oxygen flowing, the tube clear? Will she know when to call the doctor if necessary? It is such a long night before the head nurse returns. Could you, the nurse, sleep if this situation existed in your hospital? I could not.

When we discuss the values of the various types of nursing programs, how often do we stop to listen to these frightened, worried patients? What do they ask? Who? When?

Much has been said in criticism of nursing education by our friends in medicine. Because at times the doctor's criticism of nurses and nursing education seemed so unjust, because he seemed to lack understanding, because his statements seemed more related to his own personal interests, it has been all too easy to shut out the medical voice. Yet the doctor sees the lack of patient care; he sees orders inadequately carried out, and treatments become ineffective. He sees medical progress toward better care of people hampered by the lack of nurses. What does the doctor want? Who? When? Shall we shut out this voice because we do not agree? Who shall say?

The hospital administrator too has spoken. He has worried about closed beds and the implications of the situation has involved us all. He has disagreed, he has sympathized, he has hindered, he has applied pressure, he has helped. From all this shall we close our ears? He knows the trends

in institutional care. He studies the needs of his community. Shall he have a voice? Shall the health officers also be heard?

Then there are the voices of the girls, the nurses of the future. What are their voices saying? I want to nurse. I have ambition, ability, and the desire to help people sick and well. What can I afford in time and money? What is my opportunity?

Finally in this listing I place nurses themselves. There are many voices here, but also confusion. Some call only for more nurses. Some plead for better nurses. Some speak only for one type of educational program; some for another. Too many in our own profession shut out all voices save their own. Who do they really think should say?

Do you remember the story in Genesis? "And the whole earth was of one language and one speech ... and they said, go to, let us build us a city, and a tower, whose top may reach unto heaven....."

And the Lord came down to see the city and the tower, which the children of men builded. And the Lord said, "Behold, the people is one, and they have all one language; and this they begin to do; and now nothing will be restrained from them, which they imagined to do. Go to, let us go down and there confound their language, that they may not understand each other's speech. So the Lord scattered them abroad from thence upon the face of all the earth; and they left off to build the city."¹

"___ that they may not understand each other's speech.... and they left off to build the city."²

1. The Dartmouth Bible; Genesis 11, Houghton Mifflin Company, Boston, 1950
2. Ibid

Nursing too has been divided, for we cannot seem to understand each other's goals, each other's intent. How often some of us feel threatened by another's plan. How often we envy another's opportunity. How often some of us feel guilty for our differences. How often some feel loss of stature because another's program is different. So we, too, have "left off to build the city" of nursing education with one voice. Confusion, shortage, criticism, denouncement, and pronouncement continue to harrass us all. And who should say what the program for nursing education should be tomorrow?

If we are honest with our patients, our medical friends, our future students, our employers in hospitals and health agencies, we must look to the need. By need I mean both quantity and quality of nursing education for nursing service. If we are honest with the nurses to be, in the future we must provide the education which will admit large numbers of well qualified applicants to programs of high quality. We must also provide programs which the applicants can finance, programs of the length and with the concomitant opportunities attractive to the applicant and her family.

Let us be honest and courageous enough to admit and accept the facts that

All able girls cannot afford college education.

Some able girls do not want college immediately upon graduation from high school, but do want nursing.

Some able girls are strongly attracted to the hospital environment, and will not be deterred by any other form of education.

Some girls have a need to work early, and this need far outweighs the fact that a collegiate program may be more economical of time and sounder in educational planning.

Let us not forget too that each pattern of nursing education in a very real sense is dependent upon the other patterns. The university programs must supply the teachers that all types of schools may operate. The diploma and the associate degree programs must supply the nurses that patients may have direct care and that hospital services may be kept open for the education of nurses, doctors, and others. No college or university system of education can change over rapidly and soundly to absorb annually 40,000, 50,000, or 70,000 students in a special field. There is a growing demand for teachers, supervisors and administrators, soundly prepared, and a growing need for more qualified nurses for direct patient care. Who is to hold the line for the community? The people of this country must and will be nursed; nurse students must and will be taught; study and research for the future of nursing and nursing education must and will go on. If the Nursing Profession cannot fill these demands some other group will move in. Who shall say?

What is wrong with the hospital school? You have heard the comments over and over again. "It is not a part of the educational system of the country." This is true. "The students give service beyond the need for learning." This has been true in the past, and is doubtless true in most diploma schools today. "The courses are weak." This is all too true in many schools. "Teachers cannot be found." This is tragically true in many situations. This list could be extended, but discussion of existing ills will not work the cure. The list is sufficiently well known to us all.

Who shall say what we should do? Nurses or all those concerned? You may have noticed earlier when I listed the voices too often ignored I did not

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list the educator, the expert from general education. I spoke at first primarily of the quantitative need. There is no question of its importance. I would speak now of the qualitative aspect of nursing education. Quality is not determined alone by the location or the control of the program. Quality is an outgrowth of integrity on the part of the agency which conducts and controls the school, a result of knowledge and integrity of those who guide the program, and a question of courage and will which drives nurse educators to seek and use the help which surrounds their schools in hospitals and communities.

No miracle will bring the desired results. No magic can change the situation over night. The necessary steps to the goal will be arduous and many. Habits of work must be changed. New habits of thinking must be developed. Positive relationships must be sought and cultivated.

What do the directors and teachers in the diploma schools really want? What do they say should be done? We must come together and move together or we shall be divided, discouraged, and defeated.

Let me illustrate. What happens when a school is to be surveyed or resurveyed for accreditation? Soon the hospital administrator, the doctor, the advisory council of the school, all are convinced that the accreditation process is unrealistic, unfair, time-consuming, unnecessary. How do these people get their opinions? From whom? From us, the nurse educators. Why does the administrator feel the process of accreditation is nonsense? Who has told him there are too many forms to fill in? We the nurse educators, of course. Whose fault is it that the membership of the American Hospital Association questions our methods of accreditation? Do we want accreditation to help us improve? Do we stand together?

Where do we look for ways and means to improve our programs? We

wonder what the university school is doing. We seek information from many other schools to see how they have changed their programs. Then, presto, we try to introduce the same changes. True, too few schools have teachers with the right preparation to see, with the imagination to explore, with the knowledge to bring about sound change. But how many of these schools are seeking the men and women around them in general education to find help in analyzing their own weaknesses and strengths and to make a plan which is rightly adapted to their situation?

A school comprises able students rightly selected. Where can help be found to strengthen a committee on admissions? From the college or high school in the community? From the school's advisory council? From the hospital's department of psychiatry?

A school comprises teachers. Here, you say, is the hitch, and indeed this is a major problem. Too few in number, too little in preparation, and too lacking in experience these young women come to the diploma schools. How are the hospitals helping? Are they giving scholarships to promising graduates for summer study or for longer periods of study? Are they providing consultation? Are they planning to help teachers go to the shortened courses now to be provided under public law 911? Who sets off such a chain reaction? Do you the director, the teacher?

A school rightly is the curriculum. Who is talking about your curriculum plan now in teachers meetings, in advisory council, in any other situation where appropriate ears can be found? Are you, the teacher, the director, the alumnae?

A school includes facilities. The hospital has a deficit you say, it

cannot give more. What is the advisory council doing to support your need? Have we reached the point of no return with what we have? If so, what is to be done? Who is making the plan for today and tomorrow, and 1970?

A school costs money. About this there is no question. Cost studies are not quickly done. Moreover no one could be so lacking in understanding today as to believe that a school of quality can earn its way. Courage to make decisions, integrity to seek the facts, wisdom to present the case, tenacity to hold on until the chosen goal is reached. This is part of school administration. This is part of program planning. This is our job, fellow administrators.

This is building for the future. No one, or no one group can do this building for all schools. Broad patterns can be provided, methods of evaluation can be offered, but a patient-centered plan for teaching made effective by student-centered methods of learning must be designed in detail by and for every school.

We do not need to be apologetic or ashamed because we help to conduct diploma programs in hospitals. We do need to be apologetic when we conduct weak schools, when we graduate nurses inadequate to the patients' needs, and the evolving pattern of patient care. As directors of schools it is our responsibility to know and to be able to guide the teachers in their planning. As teachers it is our responsibility to see the needs in our own situations, to know the broad plan for nursing education, honestly to provide opportunity for sound learning, to see that students are stimulated to use this opportunity, and to interpret this plan whenever we can. Hospital administrators who want schools should feel obligated to assist through support and administrative guidance. Members of the advisory council should study the over-all

problems of nursing education, and when appropriate to faculty planning, seek assistance for the school through channels open perhaps only to them as members of other community groups. I include no comment on the responsibility of the medical staff, since doubtless none are here to participate in the meeting, but they too have a supporting role and a teaching role, both of which are often of little value because the medical man fails to see these roles in proper perspective to his other activities.

Who shall say what is to happen to the hospital school? Quantity will stimulate it. Mediocrity will close it. Quality built with the help of those who value this source of nurse power will bring progress and strength. The hospital school is not a misfit because there is no parallel in other comparable educational fields. The hospital school is not an outworn educational pattern because new types of programs have been introduced. It can stand as a source of supply of quality nursing if we as nurses will. But, who shall say?

2-19-60

RS:td

The Massachusetts General Hospital School of Nursing, one of the three first schools in the United States, was opened in 1873. Today the enrollment stands at 400. It is one of 12 schools in the country with an enrollment of over 350 students. As one of 57 schools in Massachusetts today, the Massachusetts General Hospital School graduates 6% of the nurses produced in the State.

The program of the School has not only kept pace with medical progress and changing patterns of patient care, but has demonstrated new methods of organization and teaching. A nurse internship, the first introduced in a hospital school, was established in 1948. This has brought new educational advantages. Freedom from service pressures the first two years offers new opportunities in nursing to learn. Assignment to patient care as planned in the third or internship year brings unique opportunities to move into graduate nurse responsibilities while under educational guidance. During the third year the nurse interns if she wishes may also begin study at one of the local colleges.

Four thousand, eight hundred and ninety-six nurses have been graduated from the School. They work today in all fields of nursing in hospitals, visiting nurse services, industries and offices. They teach in schools of nursing in hospitals, junior colleges, and universities.

The great need of the School today is for adequate teaching facilities. Over 250 different class sessions must be planned each week. If the School is to grow either in improved program or increased enrollment more space must be found.

The Commission on the Status of Women, established in 1946, was the first of its kind. It was created by the United Nations to study and report on the status of women in all countries. The Commission has since held several sessions, with the most recent one in 1995. It has produced a wealth of research and recommendations on a wide range of issues affecting women, including education, employment, health, and family life. The Commission's work has been instrumental in shaping international policy and promoting the advancement of women worldwide.

The Commission on the Status of Women has been a key player in the development of international law and policy regarding women's rights. It has played a central role in the drafting and adoption of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979. The Commission has also been instrumental in the development of the Beijing Declaration and Platform for Action in 1995, which is a landmark document in the history of women's rights. The Commission's work has been recognized by the United Nations and other international organizations, and it continues to be a leading authority on issues related to the status of women.

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SECRET
CONFIDENTIAL

INFLUENCE OF TRENDS IN MEDICAL AND HEALTH CARE

ON THE NURSING SERVICE

TRENDS IN MEDICAL PRACTICE

Early ambulation proves its worth.

The chemotherapeutics and antibiotics are here to stay.

The isotopes offer new possibilities for diagnosis and treatment.

More technical devices are used for patient care and comfort.

Psychosomatic medicine has a new emphasis.

Medical research is intensified.

Medical practices bring longevity to the American people.

The hospital patient is growing older.

Rehabilitation of every individual becomes urgent in modern society.

More medical care can be given satisfactorily in the home.

The patient becomes a partner in the medical home care plan.

EFFECT ON NURSING PRACTICE

The character of illness ^{diff. in disease} is changing. ^{diff. in patient needs}
adm., clothes, val. records ^{rapid turnover}

New administrative demands appear with the acute services.
^{interdepartmental activity - planning for teaching, discharge}

Old practices and procedures disappear. ^{dressings}
^{wound irrigations}
^{hypodermoclysis}

The new technics demand new skills,

new equipment and new admin-

istrative plans. ^{sections,}
^{drainages,}
^{transfusions}
^{I.V.}
^{I.M.}
^{tents, masks}
^{respirators}
^{tourniquets}

Psychiatric aspects become part of everyday nursing.

^{patients response to environment}
^{to own illness}

Nursing takes responsibility for new tests and added records.

The chronic, degenerative diseases bring new demands.

Nursing the aged is different.
^{Aged patient like very young needs special consideration}

Physical and emotional care of the "crippled" and chronically ill is a stimulating challenge.

^{nurse shares in rehabilitation - exercise}
^{emotional adjustment}

Hospital and home care can be 2 parts of a single plan.

^{continuity important - patient prepared in home to continue care under doctor's direction + nurses supervision in the home}
The baby "rooms in"; the parent

can help with the child's care; and patient and family want to learn "how to do".

Only when all know how, what and why is necessary cooperation possible.

TRENDS IN HOSPITAL CARE

Hospital costs continue to rise.

Blue Cross and Blue Shield increase the private patients.

Auxiliary workers come into wards to meet demands for patient care.

The patient becomes both patient and guest. - *whole patient*

The development of the group-practice or team approach to medical care.

TRENDS IN THE COMMUNITY

Facilities for the sick increase in the community.

Industry influences hospital personnel policies.

The public which supports the hospital has a right to know.

TRENDS IN THE FIELD OF NURSING

Demands for nursing service outstrip the supply.

The nursing profession has a shifting population.

More young homemakers are returning to nursing.

The retired nurse is also coming back to nurse.

The democratic way is accepted in nursing

EFFECT ON NURSING PRACTICE

New business methods require nursing time.
new charge slips, new records,

Pressures rise with high occupancy in private services.

The non-professional workers in the nursing staff must be trained and integrated.
shortage of nurses brings new helpers
The nursing schedule gives way to family and friends.

Patient no longer comes to hospital to be treated according to methods which fit staff - now treated as whole patient - "all day results"
Group practice opens new possibilities for care of whole patient - *brings new demands for hospital care*

EFFECT ON NURSING PRACTICE

The nurse has a new community responsibility.

Referral - knowledge of community

There is conflict between ward demands and the interests and "rights" of workers.

Hospital workers need personnel policies of interest of nursing administration
Nursing takes on a public relations program.

Consideration for public interest visitors, reports, talks.

EFFECT ON NURSING PRACTICE

A new system of nursing service must evolve.

How can many types of workers be integrated for effective care?

Studies are needed of nursing of patients, of workers, of inter departmental activities.
A new in-service program must be developed.

For all groups

The part-time nurse brings a new problem in staffing.

How fit time available into pattern

The retired nurse must be refreshed.

Refresher courses

All must share

What do these changes mean to nursing

Studies of changes and emerging trends

Plans to meet new demands

1. By personnel

~~new workers~~
~~in service programs~~

New courses to introduced new workers or return former

new emphases on interpersonal relationships

Reorganization of nursing service administration

in light of new hosp admin practices - records etc.

Employment of different and differing groups

Making the available help helpful

Keeping personnel policies in step with changing trends

2. By Reorganization of nursing care patterns

Realignment of functions

Assigning non-nurse workers to functions formerly carried by nurses

Assigning nurses to activities which require nursing knowledge and skill

Introduction of team plan to make total patient care possible for a group - from case method of assignment to one nurse to case method of assignment to the team

Introduction of ^{an administrative secretary in the ward staff} ~~the ward manager~~ to free head nurse for direction and supervision of patient care and personnel management

3 By in-service training programs for every group
To make every worker an effective worker and to
make every worker a secure individual
Supervisor, head nurse, staff nurse, licensed attendants,
aides, ward helpers, secretary, etc.
To orient the new worker - to stimulate and keep up
to date the worker already employed

4 By introduction of centralization
Operation of central supply room and where
necessary adjuncts of central supply such as a
suction equipment room or appliance room
Conduct of errand service to keep nursing workers
with the patient

5 By studying the various phases of nursing care
and nursing service to simplify the activities or process
thereby reducing time required and making the activities more
easily learned or accepted by the worker

5. By interdepartmental cooperation to furnish
best possible services with least use of nurses
time -

Turning over to housekeeping all functions best
performed by that department

Transferring to dietary department the food services
which this department also is best prepared to
carry.

Cooperating with pharmacy to secure most
economical service in terms of nursing time and
most economical administration of medicines

Cooperating with accounting department to
reduce the bookkeeping on the ward to the
minimum

Cooperation with School to offer best ed program
to right relationships to patient & sacrifice of nursing
care & respect to employed nursing staff -

6. By joint planning with hospital administration
+ when pertinent other department heads
medicine and nursing, for patient care to secure
understanding of all for the work, problems, and
plans of all

7. By introducing into the organization a democratic
philosophy which all will feel and share

Making opportunity for every worker to have a voice
Encouraging every worker to feel a responsibility
for his work and for improving his function
Encouraging the worker to feel a responsibility
for the hospital's success and reputation

By respecting every worker for his contributions
if he does ^{well} ~~the~~ work ^{assigned} ~~work~~ to him ~~to~~ and by
letting the individual realize this respect

Should nursing be resp for ancillary
services such as CSR
Appliance
Enamel service
etc

Reorganization of nursing Admin & care
Units of new services - into
groups - part of interdisciplinary
coordination of nurse care dept
to deal w/ of mod care +
changing attitude towards pt

How can admin best evaluate flexibility
phys set up, assign,

How educate doctor, hosp admin,

Teaching methods - at bedside

Admin team
Admitting to free nurses to care for pt.
Room ready - housekeeping help
Appliances ready
Planning team
Orders in - cooperative action
Physician team
Nursing team ready to care -
Physician
Rehabilitation as well as therapy

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NATIONAL LEAGUE FOR NURSING
Department of Diploma and Associate Degree Programs
10 Columbus Circle, New York 19, New York

REPORT OF THE CHAIRMAN
OF THE
COUNCIL OF MEMBER AGENCIES

April 1960

Ruth Sleeper
Director, School of Nursing and Nursing Service
Massachusetts General Hospital
Boston, Massachusetts

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THE PENDULUM AND THE CLOCK

The story goes that a man finding his clock had stopped took the pendulum off and carried it to a store where clocks were repaired. "I want this fixed," he said, "So my clock will go." "But where is the clock that needs repair?" asked the repair shop man. "Oh," replied the customer, "I didn't bring the clock. It's the pendulum that stopped."

Perhaps this point of view is not as uncommon as we think. Many people there are who do not look beyond the pendulum to see the clock as a whole—the face presented to the public, the unseen machinery with its key that starts operation for 24 hours, seven days a week, 365 days a year, the special construction added to accomplish a special objective, the oil which prevents friction between parts, the case which surrounds and holds together, and in a sense controls or even limits the action of the whole. There are people behind the clock who wind, dust and repair that the clock's service may be continued.

A diploma school, like the clock, needs occasionally to be viewed as a whole. No one aspect or part can be taken out, analyzed, commended or condemned alone. We have a face the public sees, too. We have many publics: the patients and their families, the applicant's, the students and their families, the medical staff, the administration, and among others our confrères in nursing. Unlike the clock, we present different faces and different voices to different people. We are the nursing service, we are the ivoried towers, we are the ones who cause the shortage, we are the ones who hold back nursing education. An interesting phenomenon, but a fact that we are not all things to all people, but rather a series of different faces and voices. A fact to be recognized and reckoned with.

The purpose of the diploma school might well be considered a special one, not in the sense of specialization, but in the sense of importance. Our main job is to prepare nurses for direct patient care. Over the years we have tended to say that the head nurse was the key figure on the nursing unit. Perhaps yes. Perhaps no. Perhaps the pendulum has so swung that today the key figure is the staff nurse. What could be more important than to prepare the keys to nursing service?

To be sure, many there are who cannot see this picture clearly. They see only the pendulum of the clock; only one part. When you were a child, did you ever have a clock which talked to you as you lay in bed trying to go to sleep at night? It said,

"Go-to-sleep, go-to-sleep, go-to-sleep, it's dark-it's dark." But in the morning the message changed, "Hurry-up, hurry-up, hurry-up. Getting-late, getting-late." Perhaps the pendulum of our clock is telling two stories today: to those who see the primary purpose of the diploma school as the preparation of nurses who will help to keep over 6,000 hospitals running safely, efficiently and humanely, it says, "Keep-on-going, keep-on-going, keep-on-going, good-job, good-job." Whereas, to those whose primary concern is the progressive movement of nursing education into the general pattern of most education in the country, it may sound like, "It's-not-right, it's-not-right, it's-not-right, wrong-system, wrong-system." The clock as a whole may not be judged by its voice.

Actually, if you are buying or judging a clock you look to its purpose—as an ornament, an alarm, a companion, or just a plain time-keeper. So, too, with the school. We must look to the purpose before we judge the appearances or the comments made about it. I wonder sometimes if we in diploma schools are closing our eyes and ears to the reason for our continuing existence. I wonder, too, if we look at objectives as something to be taken out and polished up a little for accreditation surveys. I wonder if we see these objectives as something which guide year in, year out, in the selection of students, of curriculum content, of methods of evaluation, in all our work. How much do we see these as applying to us as administrators, to us as teachers, to us as co-workers with nursing service, to the hospital administration, to the medical staff?

Since the work of this organization is actually done by the staff at headquarters, the staff will give the report today. They will show what has been accomplished this past year. In the time set aside for me, I should like to consider our objectives from a rather different point of view: (1) the objectives of the administrator of a diploma school, (2) the objectives of the teacher in a diploma school, (3) the objectives of a faculty of a school intimately and rather uniquely involved with the hospital's job of patient care, the hospital administrator's financial problem, and the continuing demand of the medical staff for service from a group whose primary objective for being at the hospital is education.

The objectives of a school administrator must be both administrative and educational. Should these be different? Perhaps not, but if the objectives for administration are not seen as distinct and necessary, the school as a whole, regardless of its strengths, may suffer.

What should be the objectives for the administrator of a school? Hers is the responsibility:

To analyze the nursing situation as a whole, foresee the problems, determine the issues to be dealt with, seek pertinent facts from all possible sources, develop possible alternatives for action, and reach reasoned decisions. She may not, doubtless could not, do this alone, but she must see that the situation is studied and that timely and appropriate plans are made for future action.

To organize the program and staff of the school, and to deal with those concerned.

To develop and maintain an effective system of communication.

To represent the school at appropriate hospital meetings, and to coordinate the school's activities with the overall hospital program to the end that the school does not interfere with the hospital program, but does benefit from the opportunities within the hospital to the end that the school may turn back to the hospital well-prepared nurses.

To represent the school, or to see that it is represented at local and national meetings.

To work for the progressive improvement of the school.

To select and develop staff.

To acquire a sound knowledge of the financial aspects of school administration and the ability to interpret and implement this knowledge effectively.

To establish standards, and to control and judge the performance of the staff.

To understand the general framework of institutional relationships, and to interpret this to the school staff.

To understand the ethics involved in education, nursing service, and interdepartmental relationships, and to develop an integrated set of ethical concepts for personal guidance in administration.

To maintain a spirit of vigorous and courageous enterprise, and a belief in the chosen objectives for the school, dealing at the same time with contingencies and continuing pressures.*

Little of this could be done by the administrator alone, but for all of it she has a major responsibility. Even in the most democratic of organizations, the administrator cannot lay aside her delegated responsibilities for others to carry. She will teach, guide, cooperate with her staff to accomplish these objectives, but the primary responsibility is hers.

None of this may be new to you. If you have not seen your objectives as an administrator as distinct and different from those of the instructors, think your goals over and set them down. My list will not fit you. No statement can be as meaningful or as helpful as your own. You will not ever achieve all you write down. Objectives, we all know, represent goals toward which to move, not hitching posts. Objectives, we know too, should be far enough away to stimulate, yet close enough to excite to action. It is our job as administrators not only to see our own objectives clearly, but also the objectives of the school staff. Furthermore, we cannot leave the teachers' objectives for them alone to select and use. We, too, are teachers, and we have a delegated responsibility to watch the school's objectives critically, to adjust those selected by our staff from time to time, to set limits, to prevent discouragement, to spot-light and, at other times, to motivate to more successful action.

What are the objectives of a teacher? To share in the preparation of a nurse, or to share in the preparation to become a nurse? This objective will vary as our philosophies, broadly speaking, vary between the diploma school and the junior college or baccalaureate degree programs. Or, to share in the transmission of nursing knowledge and the development of the skills necessary to use the knowledge? I shall not enter into the differences in philosophies here. Each school or type of school must set its own, and the teacher in her objectives must include the responsibility to use the accepted philosophy to guide her planning and her own teaching to the end that the aim of the school is most fully accomplished.

* Adapted from "Objectives and General Provisions," M.B.A. program, p.10, Education for Professional Responsibility, Carnegie Press, Pittsburgh, 1948.

This will include continuing effort toward self-improvement as needed in the position.

It will require careful planning to regulate and control the educational program in a practice field where our co-workers in nursing service have responsibility for setting and maintaining the standards of nursing care.

It will necessitate active participation inside and outside of the school in nursing affairs.

It will require an understanding and acceptance of ethical concepts involved in relationships within and outside of the nursing department.

It will require conscious effort to understand and interpret the overall problems in the nursing department and the hospital, and conscious effort to see the school's needs and responsibilities within the total nursing and hospital framework.

The instructor, too, will need to believe in the system of education within which she works, and to have the courage and the spirit to deal with pressures for change—some wise, some unwise.

Together instructors and administrator make a faculty; a faculty is not the school but it is a major component, and it does determine success or failure to a very large degree. The faculty, once integrated to act as a unit, is the pilot for the school. Often we think only of a new plan as having a pilot, a study—a pilot test, a pilot plan under a specially designated leader. Those of you familiar with the ocean or the lakes know that every ship or even the tiny boat has someone who is the pilot. Without the pilot the ship cannot follow a course or reach its stated goal. It is not just the new ship or the ship cruising on uncharted seas. It is for every ship and on every sailing. For every ship can be buffeted by storms, pressured for change, blown out of course by fair winds, or foul winds of criticism. Every ship needs to adjust its course from time to time, increase or decrease its speed, or even shift its ballast or throw it out. The pilot gives the signals. He studies the winds to see whether he should hold the course or tack awhile or even completely turn about. He charts the course to reach the goal by careful study of all the forces around the ship. But he does not change his primary aim, he does not lose courage, he knows the potential of the crew and the value of his cargo.

Perhaps I have been shifting my metaphors a little too much from pendulums to pilots, but it seems to me as I hear the wind whistle through the ship's masts I can also hear the ship's clock ticking, "All's-well, all's-well, all's-well."

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Postscript

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Dear

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Sleeper, Ruth - H.P. Return to Helen Sherman

HAVE YOU CHECKED YOUR VALUABLES?

by

RUTH SLEEPER

MASSACHUSETTS STATE COUNCIL OF STUDENT NURSES

ANNUAL MEETING

and

FLORENCE NIGHTINGALE SERVICE

MAY 17, 1960

BOSTON COLLEGE

HAVE YOU CHECKED YOUR VALUABLES?

I suspect every one of you here tonight has admitted a patient. In the process most of you have said to that patient - "And now may I check your valuables with you?" To you all this meant money, jewelry, watch, glasses, and other articles with monetary value. To some of you this meant also the little trinkets of no financial value at all. Some of these had sentimental value because of the giver. Some had supporting values because they symbolized faith. Some, like promisory notes, had no immediate worth but held hopes for the future; something to depend upon some day.

Tonight I should like to talk with you about your "valuables." You, too, brought valuables one September when you were admitted to the school of nursing. In a sense your valuables on entrance were checked during the school's admission procedure. These early valuables doubtless included your educational qualifications, your character and personality, your interest in becoming a nurse, your money for tuition and fees. Some of what you brought had great value, other parts of your offering little value or even a negative value. Like the patient's belongings the worth of each tends to vary in the eyes of the individual who owns, and the individual who does the checking. The fact always remains that value is not just a matter of money. Worth is merit, esteem, desirability. Valuables or values in terms of money are of tremendous help when needed, but in a sense they are momentary. Valuables in terms of merit and of excellence are enduring. Valuables in terms of money go up and down with availability. Valuables in terms of merit grow with encouragement and deepen with use, to shape and enrich the life of the possessor.

Have you checked your valuables recently? How do they differ today from those of the girl who came into nursing one year, two years, three years or more ago? Let us put opportunity first on the list tonight. I have placed it first not because it has primary importance in my thinking. I have placed it first for you, lest you tend to be opportunists and need concrete illustration of the values inherent in your chosen profession.

You have without doubt chosen one of the most challenging of all the careers open to women in the latter half of the 20th Century. Some women may choose a business career because it offers exciting competitive opportunities. Some may choose a career in the expanding field of science because a whole new opportunity for adventure lies ahead in yet unexplained areas of the world around us. But you of all the young women have chosen your career in medical science. You have chosen to help to keep people well; to help to enable people physically and emotionally to withstand the demands of a new age; to help to make constructive and happy lives possible. You, too, have unexplored fields, for you in your lifetime will give care about which my generation has never known or even dreamed.

You may share at home; you may share abroad. You may work in hospitals or public health agencies where the patterns of health and sickness care are well established. You may go with the World Health Organization, or the United States International Cooperation Administration, or with the military services to countries where the most elementary of health services exist. Here at home you may have the thrill of caring for patients whose leukemia then can be controlled with newly discovered drugs, or whose cancer can be cured. It will be no greater accomplishment than my generation saw when insulin was introduced in the early 1920's to save the diabetic who previously had no chance for life, or when liver extract was given to the

patient with pernicious anemia, who previously had no alternative but death in spite of innumerable and ineffective transfusions. These were the miracles I shared. You, too, will see miracles in your time here at home. Or, you may go abroad to share in the eradication of malaria, the battle to reduce infant mortality, or to teach in a school of nursing in a country where the profession of nursing is yet to be established. You may even be a nurse on a space ship. The opportunities which await you are a valuable beyond price. Is it on your list? Are you getting ready to possess it?

As you look at the patient's valuables there are often some which are in a sense contributory. Alone, they may have little monetary worth, but they are supportive, they bespeak care - like the Blue Cross Card; love, like the wedding band; faith, like the tiny Cross. What are your supporting valuables?

Is knowledge one? Are you getting all you can, or are you getting by. Speaking of the Olympic Games an author said recently "The most important thing in the Olympic Games is not to win but to take part, the most important thing in life is not the triumph but the struggle; the essential thing is not to have conquered but to have fought well."¹

Learning is not a matter of getting grades, it is a matter of participating, a matter sometimes even of sacrificing social interests to secure the knowledge and to develop the skills which prepare for life and for career. Every generation joining a profession has a dual responsibility, first of all to give the service for which the profession exists. This is the *raison d'etre*, the reason for which the public supports the profession. Second, every generation has the responsibility to see that the knowledge of the

1 A Propos of Revival of Olympics, Baron Pierre de Coubertin.

profession is passed on to the next generation, knowledge which has been reanalyzed, newly refined and once more augmented to meet the evolving need. All of this takes faith. The student's faith in the teacher who passes her knowledge on. The students' and the graduates' faith in the value of the work to be done. The faith in one's self and one's co-workers that nursing is important in the lives of our people, and so deserves the best knowledge possible.

Then there is skill, another valuable. Too often we in nursing think of the manual skills. And they are important. But there is skill in working with and management of people. There is skill in teaching. There is skill in communication. There is skill in judgment. Perhaps this latter is most important of all, for without the ability to judge, to discriminate, decision would be left to trial and error, a fertile soil for mistakes.

We must not omit attitude from our list of valuables. The will to learn, the drive to do, the feeling for the work and for the subject of all our learning, the patient.

An adventure in knowledge, skills, and attitudes, this is learning, an experience on which the teacher takes the student. Respect for the experience, respect for self as an adventurer seeking excellence at all stages, this is learning. Curiosity to seek knowledge, a lively desire to know the best, and to do the best, this too is learning. Professional valuables these; supports for a challenging life in the profession of nursing.

There are other valuables needed too. For it takes the right woman or man to make a nurse. What did you present on entrance to show your merit for nursing? Has your value gone up or gone down since you came? Physically you say you are very well. If I were using a check list I might

perhaps check off 20 points for that value. Emotionally, you say you have no mood swings, you can meet pressure, you can take criticism or disappointment without undue strain; well, let's add perhaps another 20 points.

Character you note is sound. What is this thing called character? Is it a critical sense of values or wisdom? This would make 20 more points. Is it a feeling for the good, a disesteem for evil? We could add 20 more points for this. Finally, integrity - certainly worth 20 points to make the total. A queer check list you say indeed. "What good" you say to have character if half sick. No nurse could get on with that combination. And this is true to a degree. But if you had your choice which would you choose? Would it be a person half sick but whole and sound in character, or a healthy individual with a half-sound character? Are you an independent soul with a good critical sense of values who can say "No" to wrong, who has a taste for good things? Or are you a contemporary of those who must taste all of life, right or wrong, because you are curious, you want to see for yourself. Or are you a contemporary of that much maligned Jones family which sets the pace for those who either have little will power to think for themselves or fear the comments of others who do not dare to be different. Have you stopped to think what you mean as an individual to your patients, to your co-workers, to your public? Only three weeks ago a doctor of international repute said to me "But the nurse must be the finest of all women. She is the example." Does it bother you to be an example of physical health, or of emotional stability, or of integrity, or good taste, or high personal standards?

"This learned I
From the shadow of a tree
Which (to and fro) did sway
Upon a wall -
Our influence
(Our shadow-selves)
May fall
Where we can never be."

Student nurse, have you checked up on your personal values, your personal valuables lately? So much will depend upon this check-up. Your morale you say is low. You really don't care. Life as a student nurse seems to move too slowly. In fact, life some times seems to pass you by. Morale is not fostered by such self-pity. Morale is a matter of discipline, self-discipline, group discipline, group loyalty. Morale is pride in a school, in a group, in a job, in a product, in a profession. Morale is personal. Morale is professional.

Those of you who are working actively in student organizations in your own schools have taken a major step toward building and maintaining morale. Those of you who are privileged further to share in State and National Student Associations are making still further contributions, and all of you are to be congratulated for the excellence of your organizations and participation. All Nursing is proud of you and your results.

But basic to the success of school, State and National Student Organizations, and basic to the success of the American Nurses' Association and the National League for Nursing, is the individual, both the individual who is a member and the individual who does not join. The former, the member, may contribute positively through work or passively through intentions. Upon this contribution the program of the organization and in large part the future of nursing must depend. The latter, the individual who does not join, shares like a parasite in the good works and intentions of others. Hers is a negative contribution which may all too often cancel out the contributions of those who are members.

Stocktaking time is here. The store, the industrial concern, the hospital, the school which does not take stock periodically will inevitably be wasteful. It may be overstocked and lose money from disuse. It may be

understocked and slow up production. Businesses take inventory, counting the goods on hand, comparing stock with business needs today and tomorrow. The school takes stock as it reviews its curriculum, estimates the needs in nursing today, and the changes ahead two years, and ten years. How does an individual take stock? What can an individual count? Money, real estate, clothes, jewels, books? Or knowledge, skill, attitude, character? Should an individual not count her valuables to estimate the needs of the future as well as today? The needs may not be the same. The values allowed to deteriorate today will not be easily built up again for a new life in the future. The opportunity to start the inventory is now, today, May, 1960. A wonderful year to start. In June, 1860, almost exactly 100 years ago, Florence Nightingale established the first modern school of nursing at St. Thomas's Hospital in London. Due to the knowledge, skill, attitude, and character of one woman you and I today have a priceless opportunity. It was Miss Nightingale's dream that the nurses graduating from the school she planned would be "the leaven by which the entire nursing world as it then existed was to be altered." And so it has been. It is an established fact that in the underdeveloped countries medicine can make no real progress until sound programs in nursing education are developed. In our own country when nursing is inadequate or poor, medical programs cannot be carried out effectively. Miss Nightingale strove to bring into nursing refined and educated women, and to train these women for nursing. To her training was not alone learning the manual skills necessary. It was a matter of self-development, self-discipline, self-direction. It was a matter of valuables.

On this 100th anniversary of the founding of our profession we all have a responsibility. You who will be participants, you who will prepare the nurses of the future have a special responsibility.

Students in Nursing, have you checked your valuables?

mimeograph
50 copies, please.

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BOSTON COLLEGE

HAVE YOU CHECKED YOUR VALUABLES?

I suspect every one of you here tonight has admitted a patient. In the process most of you have said to that patient - "And now may I check your valuables with you?" To you all this meant money, jewelry, watch, glasses, and other articles with monetary value. To some of you this meant also the little trinkets of no financial value at all. Some of these had sentimental value because of the giver. Some had supporting values because they symbolized faith. Some, like promissory notes, had no immediate worth but held hopes for the future; something to depend upon some day.

Tonight I should like to talk with you about your "valuables." You, too, brought valuables one September when you were admitted to the school of nursing. In a sense your valuables on entrance were checked during the school's admission procedure. These early valuables doubtless included your educational qualifications, your character and personality, your interest in becoming a nurse, your money for tuition and fees. Some of what you brought had great value, other parts of your offering little value or even a negative value. Like the patient's belongings the worth of each tends to vary in the eyes of the individual who owns, and the individual who does the checking. The fact always remains that value is not just a matter of money. Worth is merit, esteem, desirability. Valuables or values in terms of money are of tremendous help when needed, but in a sense they are momentary. Valuables in terms of merit and of excellence are enduring. Valuables in terms of money go up and down with availability. Valuables in terms of merit grow with encouragement and deepen with use, to shape and enrich the life of the possessor.

Have you checked your valuables recently? How do they differ today from those of the girl who came into nursing one year, two years, three years or more ago? Let us put opportunity first on the list tonight. I have placed it first not because it has primary importance in my thinking. I have placed it first for you, lest you tend to be opportunists and need concrete illustration of the values inherent in your chosen profession.

You have without doubt chosen one of the most challenging of all the careers open to women in the latter half of the 20th Century. Some women may choose a business career because it offers exciting competitive opportunities. Some may choose a career in the expanding field of science because a whole new opportunity for adventure lies ahead in yet unexplained areas of the world around us. But you of all the young women have chosen your career in medical science. You have chosen to help to keep people well; to help to enable people physically and emotionally to withstand the demands of a new age; to help to make constructive and happy lives possible. You, too, have unexplored fields, for you in your lifetime will give care about which my generation has never known or even dreamed.

You may share at home; you may share abroad. You may work in hospitals or public health agencies where the patterns of health and sickness care are well established. You may go with the World Health Organization, or the United States International Cooperation Administration, or with the military services to countries where the most elementary of health services exist. Here at home you may have the thrill of caring for patients whose leukemia then can be controlled with newly discovered drugs, or whose cancer can be cured. It will be no greater accomplishment than my generation saw when insulin was introduced in the early 1920's to save the diabetic who previously had no chance for life, or when liver extract was given to the

patient with pernicious anemia, who previously had no alternative but death in spite of innumerable and ineffective transfusions. These were the miracles I shared. You, too, will see miracles in your time here at home. Or, you may go abroad to share in the eradication of malaria, the battle to reduce infant mortality, or to teach in a school of nursing in a country where the profession of nursing is yet to be established. You may ^{even} be a nurse on a space ship. The opportunities which await you are a valuable beyond price. Is it on your list? Are you getting ready to possess it?

As you look at the patient's valuables there are often some which are in a sense contributory. Alone, they may have little monetary worth, but they are supportive, they bespeak care - like the Blue Cross Card; love, like the wedding band; faith, like the tiny Cross. What are your supporting valuables?

Is knowledge one? Are you getting all you can, or are you getting by. Speaking of the Olympic Games an author said recently "The most important thing in the Olympic Games is not to win but to take part, the most important thing in life is not the triumph but the struggle; the essential thing is not to have conquered but to have fought well."¹

Learning is not a matter of getting grades, it is a matter of participating, a matter sometimes even of sacrificing ^{personal interests} to secure the knowledge and to develop the skills which prepare for life and for career. Every generation joining a profession has a dual responsibility, first of all to give the service for which the profession exists. This is the *raison d'etre*, the reason for which the public supports the profession. Second, every generation has the responsibility to see that the knowledge of the profession

1 A Propos of Revival of Olympics, Baron Pierre de Coubertin.

is passed on to the next generation, knowledge which has been ^{re}analyzed, ^{revised} refined and ^{once more} augmented to meet the evolving need. All of this takes faith. The student's faith in the teacher who passes her knowledge on. The students' and the graduates' faith in the value of the work to be done. The faith in one's self and one's co-workers that nursing is important in the lives of our people, and so deserves the best knowledge possible.

Then there is skill, another valuable. Too often we in nursing think of the manual skills. And they are important. But there is skill in working with and management of people. There is skill in teaching. There is skill in communication. There is skill in judgment. Perhaps this latter is most important of all, for without the ability to judge, to discriminate, decision would be left to trial and error, a fertile soil for mistakes.

We must not omit attitude from our list of valuables. The will to learn, the drive to do, the feeling for the work and for the subject of all our learning, the patient.

An adventure in knowledge, skills, and attitudes, this is learning, an experience on which the teacher takes the student. Respect for the experience, respect for self as an adventurer seeking excellence at all stages, this is learning. Curiosity to seek knowledge, a lively desire to know the best, and to do the best, this ^{is} _^ learning. Professional valuables these; supports for a challenging life in the profession of nursing.

There are other valuables needed too. For it takes the right woman or man to make a nurse. What did you present on entrance to show your merit for nursing? Has your value gone up or gone down since you came? Physically you say you are very well. If I were using a check list I might perhaps check off 20 points for that value. Emotionally, you say you have no mood swings, you can meet pressure, you can take criticism or disappointment

without undue strain; well, let's add perhaps another 20 points.

Character you note is sound. What is this thing called character? Is it a critical sense of values or wisdom? This would make 20 more points. Is it a feeling for the good, a disesteem for evil? We could add 20 more points for this. Finally, integrity - certainly worth 20 points to make the total. A queer check list you say indeed. "What good" you say to have character if ^{half sick} physically ill. No nurse could get on with that combination. And this is true to a degree. But if you had your choice which would you choose? Would it be a person half sick but whole and sound in character, or a healthy individual with a half-sound character? Are you an independent soul with a good critical sense of values who can say "No" to wrong, who has a taste for good things? Or are you a contemporary of those who must taste all of life, right or wrong, because you are curious, you want to see for yourself. Or are you a contemporary of that much maligned Jones family which sets the pace for those who either have little will power to think for themselves or fear the comments of others who do not dare to be different. Have you stopped to think what you mean as an individual to your patients, to your co-workers, to your public? Only three weeks ago a doctor of international repute said to me "But the nurse must be the finest of all women. She is the example." Does it bother you to be an example of physical health, or of emotional stability, or of integrity, or good taste, or high personal standards?

"This learned I

From the shadow of a tree

Which (to and fro) did sway

Upon a wall -

Our influence

(Our shadow-selves)

May fall

Where we can never be."

Student nurse, have you checked up on your personal values, your personal valuables lately? So much will depend upon this check-up. Your morale you say is low. You really don't care. Life as a student nurse seems to move too slowly. In fact, life some times seems to pass you by. Morale is not fostered by such self-pity. Morale is a matter of discipline, self-discipline, group discipline, group loyalty. Morale is pride in a school, in a group, in a job, in a product, in a profession. Morale is personal. Morale is professional.

Those of you who are working actively in student organizations in your own schools have taken a major step toward building and maintaining morale. Those of you who are privileged further to share in State and National Student Associations are making still further contributions, and all of you are to be congratulated for the excellence of your organizations and participation. All Nursing is proud of you and your results.

But basic to the success of school, State and National Student Organizations, and basic to the success of the American Nurses' Association and the National League for Nursing, is the individual, both the individual who is a member and the individual who does not join. The former, the member, may contribute positively through work or passively through intentions. Upon this contribution the program of the organization and in large part the future of nursing must depend. The latter, the individual who does not join, shares like a parasite in the good works and intentions of others. Hers is a negative contribution which may all too often cancel out the contributions of ^{those who are} ~~the~~ members.

Stocktaking time is here. The store, the industrial concern, the hospital, the school which does not take stock periodically will inevitably be wasteful. It may be overstocked and lose money from disuse. It may be understocked and slow up production. Businesses take inventory, counting

the goods on hand, comparing stock with business needs today and tomorrow. The school takes stock as it reviews its curriculum, estimates the needs in nursing today, and the changes ahead two years, and ten years. How does an individual take stock? What can an individual count? Money, real estate, clothes, jewels, books? Or knowledge, skill, attitude, character? Should an individual not count her valuables to estimate the needs of the future as well as today? The needs may not be the same. The values allowed to deteriorate today will not be easily built up again for a new life in the future. The opportunity to start the inventory is now, today, May, 1960. A wonderful year to start. In June 1860 almost exactly 100 years ago Florence Nightingale established the first modern school of nursing at St. Thomas's Hospital in London. Due to the knowledge, skill, attitude, and character of one woman you and I today have a priceless opportunity. It was Miss Nightingale's dream that the nurses graduating from the school she planned would be "the leaven by which the entire nursing world as it then existed was to be altered." And so it has been. It is an established fact that in the underdeveloped countries medicine can make no real progress until sound programs in nursing education are developed. In our own country when nursing is inadequate or poor, medical programs cannot be carried out effectively. Miss Nightingale strove to bring into nursing refined and educated women, and to train these women for nursing. To her training was not alone learning the manual skills necessary. It was a matter of self-development, self-discipline, self-direction. It was a matter of valuables.

On this 100th anniversary of the founding of our profession we all have a responsibility. You who will be participants, you who will prepare the nurses of the future have a special responsibility.

Students in Nursing, have you checked your
valuables?

FORESIGHT, INSIGHT, HINDSIGHT

GUIDES TO ACTION

BY

RUTH SLEEPER

TENNESSEE LEAGUE FOR NURSING

JUNE 8, 1960

FORESIGHT, INSIGHT, HINDSIGHT

GUIDES TO ACTION

Foresight, insight, hindsight, which shall it be for the National League for Nursing? Which shall it be for Nursing? Which of these three guides should direct the action for nursing care and nursing education of the future? Here are three questions, and three possibilities for action. Shall we in our planning do best if we lean heavily on foresight, the power or act of seeing in advance? Shall we make more rapid, more positive progress, if we depend upon insight or discernment? Or, if we look back to see the values achieved, the progress made, shall we find the most helpful tools for future planning?

Surely to be able to see ahead ten, twenty, or more years would be an excellent guide. To know that today we are building soundly for the nurses of 1980 or 1990 would have immense value. We of the mid-century hold great responsibilities in our hands. Unwise planning will reflect not just in nursing education. It will be apparent in the health of our Nation. So great is the decision; so large is our power. Meet this responsibility we must, if we are to have reason to continue as a profession.

What guides to action should we use? There is of course foresight. To some this means a good guess. To others it is a matter of foreseeing only what the individual wants to see. Do you remember the childhood story of the farmer who had no patience with the weather? He wished he could plan things his way. Then he would grow better grapes than anyone else to make his wine. He knew what made grapes grow. He knew he could improve upon the weather. Just give him a chance. As in all myths his wish was granted. He planted.

He ordered the sun. He added just the right amount of cloudy days. He planned for rain. The vines flourished. The bunches of grapes were large. The harvest came. The wine was made. But, the wine! It was sour. Alas he had forgotten the wind, the soft summer breezes which kept the vines in gentle motion. This man had foresight - of a kind. He could see what he wanted. What else was there to do but to go ahead, to plan.

Foresight without insight. He did not bother to study the situation. His way of life was based on wishful thinking not heedful thought for the future. His action was suited only to life in fables, not to reality or to serious responsibility. We need insight into the future. We need insight into the needs to be met. We need studies of goals and methods. We need facts, figures, and principles which determine health, medical, and sociological changes. We must know, in so far as we can know today, what the future will hold, and what the future will need. We need to be knowledgeable, discreet, daring. Most of all we need to give the time and thought required to look into, to use our insight.

We might well stop at this stage to ask where the facts, figures, principles will come from to give us the data for our estimate of future action. Shall this come from studies still to be done? Can anything be gleaned from the past? Here is our third guide to action. Hindsight to me is an old New England term. Perhaps you use it in Tennessee too. Had the farmer of the fable possessed a little less self-interest, and a little more ability to look back to see the whole situation his grapes might have been different indeed. More properly expressed for us today this ability to see the future in the light of the past is inscribed on a pillar before the Library of Congress in Washington. "What is past is prologue." To study the past, to use the past

to predict the future is not necessarily to maintain the status quo. Too much looking back can of course result in stasis if an individual wishes it so. Looking back may also result in knowledge which leads to understanding, to knowledge which avoids error, to knowledge which shuns expensive repetition. Hindsight as our forbears used the word is not always a matter of casting sorrowful glances at happy events or the status quo. It may also involve a process of studying the past, clarifying understandings, analyzing earlier goals and achievements, causes and effects, actions and reactions. In fact, hindsight might well be placed first on our list, not added at the end.

Hindsight, then, to know what happened in the past and why; foresight to look ahead to judge the future growing out of today and yesterday; and insight to understand what we learn as we search past, present, and future. To place these activities in the wrong sequence produces a situation not unlike that in which an unthinking nurse might find herself. Imagine the nurse who gives a medicine, then looks up the effects of the drug, then reads the patient's history to learn that the patient is sensitive to this medication. Unforgiveable action in a nurse who should know the proper sequence of steps in giving medicine. Nonetheless unforgiveable in the director of a school of nursing, or in a teacher who fails to follow the steps to sound action in nursing education. Nor is it any different for the nursing organization which makes plans or sets goals without the necessary processes which consider first the health needs of the people of the future, and then place all other needs in their proper perspectives.

Let us apply this thinking for a few moments to nursing education. What does the past predict for us? That the health needs of the people are increasingly rising in priority. That the need for numbers of prepared workers in nursing will increase, not decrease. That nursing will work with the doctor and other health workers in an increasingly intricate, scientific

situation. That the maintenance of the human factor in patient care will be in large part nursing's responsibility. That the situation will be further complicated by the growing pressures upon the doctor. That the doctor will wish to turn over more and more responsible procedures to nursing. That at the bedside there will continue to be a need for a nurse with sufficient knowledge of science to make sound judgments. That any action which decreases the number of prepared nurses at all levels will affect national health. That any sudden, marked upward movement at any level of education for nursing will reduce number of women eligible or available for the program concerned. That nursing has grown as a profession in the proportion to which it has fulfilled its obligation to the people. That nursing, like engineering and other fields, has proved a need for several levels of education in order to produce persons needed for all types of tasks. That although education and research for professions and vocations are found usually in universities, the trend is obvious to locate more of these functions in other institutions where there is also a strong educational as well as service interest.

You will add findings to my list as you look backward too. The important question is what do we see into the findings.

As we begin to see into the past we shall find in some respects that we reached the goals for which we aimed. The goal was numbers. We achieved, but at a price. The goal became reduction of schools. We reduced, but not always achieving quality in the residue. We stretched to establish schools in universities, but sometimes the place seemed more important than the product.

It has been said "If you have a weakness make it work for you. If you have a strength don't abuse it into a weakness." The fact that our diploma schools were established in hospitals seems to many people today

to be a weakness. Look at this a moment. Who would have supported nursing education if the hospitals had not? Large financial sums and great interest are holding these schools in hospitals today. Is this not a weakness which could be put to work? The fact that students in nursing have spent too much time in patient care may also be listed with our weaknesses for this extends the time. But is a system all bad which attracts today well over 40,000 young women to its schools? Is it better to take a little longer in one's life to prepare for a career than not to go at all? Expensive to spend five years or six when four would do. Yes, but if one cannot afford four costly years at age eighteen, might one not be privileged to take the longer course? Some of our friends would tell us that the diploma school's very location mitigates against education. We are away from educational influence and guidance. To a degree true, but this need not be a severe weakness if we would seek the help which is available. Too many schools in the past were content with minimum standards. We know today how much some of these same schools have done under the stimulus of accreditation. Can we not honestly now begin to develop the insight which will make growth a constant factor in our planning, and make accreditation a matter only of adding the stamp of quality?

Look at some of our most obvious weaknesses. Lack of faculty, lack of facilities, lack of money. How overwhelming these sound. But look what has come out of the past. Look at the achievements of these hundred years since Miss Nightingale established her school. Look even at the achievements in your own schools during the past ten years. If we could combine these weaknesses with a renewed determination on the part of the existing school administrators to lead soundly, and a renewed determination of the existing faculty to learn, and if both could see into the needs of

students in nursing, and if we could add to these the dedication which drives an individual to search, to study, to reach a chosen goal regardless of what intervenes, how much this would do to make our weaknesses work for us, and our strengths to grow.

Are we using our present supply of faculty, one of our weaknesses, to produce best results? I am not being critical of our present faculty. I am looking into the past, seeing the miracles created out of nothing, and asking myself what more can we do with what we have? Out of this shortage what strengths can we find? There will not be enough faculty for years to come if my estimate is right. It is not selfishness or a desire to hold us back which encourages the university to meet its own needs first. It must be somewhat like the situation in which I find myself when a hospital without a school sends large amounts of alluring publicity to the members of our graduating class. The hospital can pay more, give more benefits et al. Of course it can. It does not use its money to run a school. But what can we do to encourage more graduates to go into teaching, to find more scholarships to help with the first degree, to encourage nearby universities to give more of the short courses for which teachers can be released, to give more in-service education which will enrich the teaching of the presently employed group?

It does sometimes seem as if many of our friends and co-workers are against us in philosophy, and so in purpose. One can expect with considerable certainty that out of every convention will come something to indicate that a segment of the NLN program has been discussed by each group in turn. Some organization each year seems to take matters of special concern to us into their own hands to make decisions which affect the organization for nursing, or the NLN program, or our system of education. This year,

the first of the year, and it is not until the middle of the year that the weather is really warm. The first of the year is the best time to visit, as the weather is just what you need. The first of the year is the best time to visit, as the weather is just what you need.

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as you know, the ANA voted "To insure that, within the next 20-30 years, the education basic to the professional practice of nursing, for those who then enter the profession, shall be secured in a program that provides the intellectual, technical and cultural components of both a professional and liberal education. Toward this end, the ANA shall promote the baccalaureate program so that in due course it becomes the basic educational foundation for professional nursing."

What is this doing to your faith in the diploma program? Are you saying to yourself "The three-year, hospital school is on the way out"? Or are you saying "Twenty-thirty years! What a challenge. Either to know why the diploma program should continue or what best will replace it." Perhaps nursing education in the university will no longer be on the baccalaureate level. Perhaps nurses graduating from the university will have in truth opportunity to become educated women. Who knows what hospitals will become as time brings its changes. Perhaps they will develop education for other health groups who have seen the strengths now inherent in the diploma schools.

How will our foresight help us to be ready for whatever the development should be? Surely there is a way. Values now existing can be strengthened. The location of the program is not necessarily a deterrent to sound education. Teachers in hospital schools of nursing like all other teachers in whatever field have a mission. It is our responsibility to strive for excellence in whatever we teach at whatever level. This we must see as a one large responsibility. This will require study on the part of the teachers whether in the university or on the job. At all times the teacher must be a student. If this is not true, if teaching is seen only as an opportunity for selfish ends, for long week-

ends, and free evenings, the school is lost. A second responsibility which any school owes to its students is the opportunity to learn something about the art of living. These two functions of a school are not the prerogatives just of colleges and universities. They can be found in secondary schools. They can be found in significant degrees in good technical schools. Can we teach these in the diploma school?

If we can achieve these two goals we shall have fulfilled our purpose. Hindsight will show our progress, insight will show the worth of our achievement, and foresight will keep us on the right road.

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THE
MILLER

REPORT TO THE COUNCIL OF MEMBER AGENCIES OF THE
DEPARTMENT OF DIPLOMA AND ASSOCIATE DEGREE PROGRAMS

To be, not to be, or what to be, this is our question. This is the question which comes first to my mind as I start the report to you. I have met this past year with the Steering Committee of the Department of Diploma and Associate Degree Programs, with two planning sessions of the Program Committee, and I have attended three of the Regional Meetings. At each one, the questions focused most strongly on the future of the diploma school of nursing.

Why does this insecurity persist after all these years of NLN activity on our behalf? The NLN statement will be voted on again by this Council tomorrow. It reads in part: "These statements are intended to: 1-express the belief of the NLN and its membership in sound, educationally oriented diploma programs and associate degree programs; ----"¹ NLN has of course affirmed its belief in the basic baccalaureate program too. This does not mean less support for our three-year programs, but rather a belief in three accepted basic patterns to prepare the registered nurse

Why, then, our uneasiness? Why did your representatives in all six of the Regional Conferences give priority to the issue: "The future status of the diploma program"? Why did they list as the major problem "Changing patterns of nursing educational programs"?

Let us look at the plus and minus of our concern. 1) We find among nurse educators those who believe that the future of nursing education lies in the basic baccalaureate and the junior or community college programs. Those who speak for these patterns of nurse education are often members of college faculties, some are leaders in the NLN and in its Department of Baccalaureate and Higher Degree Programs.

1 Background Information for Statements of Characteristics of Diploma and Associate Degree Programs in Nursing. NLN, October 1960.

2) Many of you in May listened to or later read the ANA Goal for Nursing Education: "The Committee on Current and Long-Term Goals presented a report on nursing education for the future to the House of Delegates for study. --- 'Only with a truly professional education can nurses meet society's needs and the nursing profession maintain its strength at a time when the general education level of the population is rising constantly. Nurses, as professional persons, must not only be willing, but able to meet on equal terms with persons of other professions in planning for the health and welfare of the public. With this in mind the nursing profession, through the ANA, is now moving toward clarification of the preparation which nurses will require as a basis for that ability in the future.' 'To insure that, within the next 20-30 years, the education basic to the professional practice of nursing, for those who then enter the profession, shall be secured in a program that provides the intellectual, technical and cultural components of both a professional and liberal education. Toward this end, the ANA shall promote the baccalaureate program so that in due course it becomes the basic educational foundation for professional nursing.'" - - -¹

3) Perhaps some of you would add other articles, publications or discussions at state conventions or with your own friends which would reinforce the ANA goal.

How have you answered these statements this year? How have you interpreted your thinking or the discussion from this Council to your Director, your Trustees, and Advisory Council, your medical staff, your faculty, your students? They have less access to information, less opportunity to learn what others are thinking. How firm is your belief in what you and the other approximately 916² diploma schools are trying to do?

1 American Journal of Nursing, June, 1962, vol. 60, no. 6, p832.

2 Facts About Nursing, American Nurses' Association, New York, N. Y., 1959., page 83.

3) Copy of our letter to the Council dated 1977, 10/10/77.

4) Copy of our letter to the Council dated 1977, 10/10/77.

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29) Copy of our letter to the Council dated 1977, 10/10/77.

30) Copy of our letter to the Council dated 1977, 10/10/77.

Now let us look at the factors on the positive side. 1) What is the diploma school doing today to meet the public need? I am not speaking now of the service which the student contributes as she learns. I am speaking of the products of our schools. Today the diploma schools enrolled 82.3%¹ of the nurses. These are not prepared for public health or industry, or for any special field of nursing. They are prepared for direct nursing care of the country's sick. True some will secure added preparation to enter fields requiring specialization, but the large majority will remain in hospitals as staff nurses and team leaders.

2) Is the public's support of our diploma schools no indication of their value? It can be said the public is uninformed, and many people are. It can also be said that many thousands of our applicants today come from families who have experienced hospital and nursing care, and so have a kind of educated opinion. The public, it has been said, is often in advance of the scientist or the educator. Less burdened by detail, less concerned about status and the concomitant authority, the public sees through the haze to glimpse the necessary goal. I do not question the desirability of broad general education. I am in favor of it. I want the nurse to speak as an equal in the health team. I believe the nurse today should do so. But, I do not want the level of nursing care to drop lower while the profession enhances its own education and role.

3) Has the moral and financial support of the Hospital and the organized hospital system of the country no meaning to us? Thirty years ago I could have agreed that the hospital's interest in the student nurse centered too much on the student's service and too little on her education. Today I find this increasingly hard to accept, and I commend to you all possible consideration

1 Facts About Nursing, American Nurses' Association, New York, N. Y., page 69.

of articles and studies dealing with the costs of hospital care and nursing education in the hospital. I recommend the study of your own budget and/or expense accounts. I question whether there are now any accredited schools of nursing in this country whose students pay in tuition and service a sum equal to 50% of the money expended on the school. Students in no schools, professional or general education, are expected to pay full cost of education. Students commonly pay the cost of maintenance and some of their teaching costs. The financial situation in our schools may above all other questions hold the key to our future. It is a question worthy of future discussion for us all. I use this illustration today, however, merely to show what support our schools have from one important segment of the public, a segment which is making a significant investment for the present and future welfare of the people of this country.

If the public whom we seek to nurse and the public which supports our hospitals with schools believes in us, surely there is time to work out our problem wisely and without fear.

ANA's goal tells us that professional education in nursing is to be moved into the college. Does this mean that ANA is not concerned with the large body of nurses who will give the patient care? This I do not believe can be true. We are ANA, and we want the best possible care. If this is so, what is our worry? Is it the loss of professional standing? There are so many definitions today of "professional". These may all be combined, but often each phrase in the definition is used out of context from the others. To one person being professional is a matter of education at the senior college level. To another it is possession of a special body of knowledge. To still others it is the ability to carry out the occupational duties without supervision.

Those of us who have watched nurses over many years might like to add that ideals of practice should in some way be included in the list of criteria for a profession.

Recently I talked with the president of a technical engineering school. This school has high standards and is well thought of. It is located in a city where there is also an outstanding engineering college. The technical school attracts a sufficiently large number of applicants to admit 1,200 students of good quality each year. I asked the president: "How does your faculty feel about teaching in a technical school? How do your students feel as graduates of a technical school in lieu of a college?" His response showed surprise at such a question. The faculty was proud of its school, its equipment, the excellence of the program, the young men who were graduated. The students chose the technical school sometimes influenced by ability, but often because they were young men who liked action, the contact with machines, not desks. They got good jobs. They were proud to be graduates of this technical school.

Now I do not believe our schools are technical schools, nor should they be classified so, but they are different from collegiate schools and must of necessity always remain so if the present organization is retained. I wondered during that conversation, as I do now, what is our problem, those of us in diploma schools? Do we feel more concern for our school status in terms of social rank, or the status, that is the authority, our graduates are to have? I do not believe this. I believe our applicants sometimes choose us, like the engineering students, because requirements are more possible, because costs are less, because time is shorter. Often I am sure our applicants come to us because they want to be with the patient, they are young women of action. They wish to

be practitioners. They want to understand and work with people.

Now I like you cannot really predict the distant future for our schools. We both know we need nurses today and that every effort must be expended to increase, almost double, the number of students in our schools in the next 15 years. We both know to do this there must be more teachers, administrators, supervisors, and this supply really should come before our schools are enlarged. No one yet knows what Government may do to help Nursing Education. Surely we can see that approximately 90,000¹ student nurses could not suddenly be moved into already over-crowded colleges and universities. And for such a move 15-20 or even 30 years is sudden. I believe today we need a study or some studies to point the way for the diploma school. ~~If accreditation must stop to permit this, let us so consider. Accrediting has helped to raise the level of diploma school education. Accreditation can also stifle our education if we are not in agreement on our goal and the route to this goal. In a period such as this, schools may be retarded by lack of understanding, or they may be helped by wise guidance. Has the time come for reconsideration of our needs? I repeat my first question. It is not a question of whether the diploma school is to be, or not to be. It is a fact that the school must now be, and a question of what the diploma school is to be and where it is to stand in the nation's system of educating its nurses.~~

Ruth Sleeper, R.N.
Chairman

RS:BF
3-8-61

the present. They want to know what you think of it.

Now I think you cannot really know the meaning of love for

our people. It is not a word to be used lightly, and it is not

an emotion to be felt. It is a word of power, and it is a word

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Yours truly,
John F. Kennedy

1961

Who should do such studies? I cannot say at this time. This must be the decision of our diploma school leaders. What such studies should include? Should they be short and simple or comprehensive and prolonged? Perhaps the League should seek some assistance, but the need is for immediate help. May I add, let us have assistance this time which sees the value and the need of the diploma school. There have been three major studies beginning with the Rockefeller Report in the early twenties. All have been pointed toward the need for university school education. We must not stop now to quarrel over the objectives of these previous studies. They had great value. Much needed leadership was aroused. Without the university programs which these studies advocated we should lack even more the supply of teachers and administrators. We should have no programs to give impetus and method to leadership.

But now another era has come. Now the diploma school has not only proved that hospital-controlled programs can be more educationally centered. Now we know that the health service of the country is to be dependent upon diploma schools for years to come. Now we need a study to help our schools, not to depress them; to point the way to continued growth, not to hold them back.

Much improvement has been brought about in our schools by the accrediting program with its emphasis on school improvement. At this stage it is time to decide whether we are looking to growth or to standardization. What is accreditation? What is an improvement program? Is accreditation standardization? Will a fixed pattern bring growth or stultify? Are we prone to seek the comfort of similarity rather than the uneasiness of creativity?

Are we at the crossroads where we should stop to find our direction for the next twenty years?

Has the time come for reconsideration of our future? Should we stop accreditation for six months to find our way? Should we seek means to study our needs while accreditation is continued? We cannot afford the luxury of fragmentation of our loyalties. Only together can the members of a Council such as this find strength. We cannot afford the mediocrity of standardization. I say to you, it is not a question of whether the diploma school is to be, or not to be. It is a fact that the school must now be, and a question of what the diploma school is to be and where it is to stand in the nation's system of educating its nurses.

Ruth Sleeper, R.N.
Chairman

WHO IS TO SAY?

by

RUTH SLEEPER

Vermont League for Nursing
Stowe, May 24, 1962

When we talk about health care, the nurse. The person
woman at the bedside - the 7% of our students
of two of them is our 3 year nurse. Pediatrics
just as we would as not only better education
that a nurse will in these years there is
carry from these activities which nurses
+ considering the role of our nation

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WHO IS TO SAY?

Three suggestions were made for my discussion with you today: first, the position of the three-year graduate, is she threatened by the growing number of two-year or junior college graduates, and the status given by some to the graduate of the four-year baccalaureate program; second, how do we orient this group of nurses who come to our hospitals and health agencies with such different educational backgrounds; and third, what is the future of the three-year hospital-controlled school.

Actually all three questions are related, the status of the three-year graduate, her ability to compete in the world of nurse employment, and judging by its value, should the three-year school which prepares these graduates continue. Lest there be some misunderstanding as I speak, let me say first I stand for the best in nursing education. I believe in the worth of, and the need for, the good three-year school. I encourage the further development of good nursing programs in the junior college. I want to see the colleges and universities graduate an increasing number of the best possible nurses who are also educated women. In short, I stand for nursing education of all types. But I will take this stand only if the programs are of high quality. It is not the length of a program which makes a nurse. It is the soundness of the plan, the quality of the teaching, the attendant degree of learning, the resultant attitudes of the product toward her responsibilities. Be the program a two-three-four or five-year program it can either meet or fail to meet these standards. It is not to the length of a program to which we should look for the measure of "goodness."

There are no stations along this line.

There is a large - not hospital - convalescent school
connected with St. Francis Hospital, and this, also, is
to be visited with a group of nurses who conduct day hospitals and health
by some of the activities of the Sisters of Charity in the morning session. The
the main part of the day on their duties. The first of the
to visit the location of the three-year program. The day is spent by the

...and all these elements are related; the x-axis of the line...

... I believe that I believe in the value of the work.

development of coordinating programs in the United States. I wish to add that the United States has been a leader in the development of the world's first space station, the International Space Station, and in the development of the world's first space-based observatory, the Hubble Space Telescope.

Who is to say how nurses are to be educated? Shall we listen to the consumer? What will the consumer of nursing services want: the doctor, the hospital administrator, the director of nursing service, the health officer in the community? What does the doctor want? He sees the lack of patient care; he sees orders inadequately carried out, and treatments become ineffective. Will he speak only for that plan which increases the number of nurses? Does he stop to question educational background? Does he realize what the graduates of the three programs are prepared to do?)

The hospital administrator too has spoken. He has worried about closed beds and the implications of the situation have involved us all. He has urged increased enrollment in "his" schools, and his demands have exceeded our abilities. He has disagreed, sympathized, hindered, applied pressure, he has helped. What does he want? Is it numbers? He knows the trends in institutional care. He studies the needs of his community, as does the health officer who sees the shortages in his service too.

The director of nursing service may approach the situation differently, but her problem is not dissimilar. She has stretched the nurses as best she can, but there are not enough. She knows where the practical nurse can replace the nurse. She knows how much responsibility the aide should be given. She knows the unsafe factors in her service. What does she want? Quality nursing is her goal, but numbers of nurses, numbers of nurses to cover the need may be her conscience's first demand.

The patient, what does he say? Who would you choose to help you with the acts of daily living if you were too weak, too handicapped physically

and emotionally to carry on alone? If you were very ill indeed, and a patient in a hospital ward, would you feel secure at night with just anyone? Would it make a difference if the only nurse you saw during the night went only to those patients who needed injections and so she passed you by? Would the shortness of breath grow more frightening? Would you worry about tomorrow's operation? Would you have faith that others in the ward would keep the tracheostomy tube clear and replenish the oxygen supply? What will the patient say is needed? Numbers, procedural care, or "insightful" care, combined with knowledge of people and their needs. Who does the patient want, a two or three or four-year graduate?

What of the young women and young men, the nurses of the future? They want to be heard too. Look at them. They vary in ambition, interests, ability, time, money. Their common goal is to help people. Must they all be placed in one mold? They are not interested in numbers as they plan their futures. They may not comprehend the term "quality care" in nursing. Let us be honest and courageous enough to admit these differences, and plan accordingly: some girls and boys see for themselves special values in a college education; all girls and boys cannot afford a college education; some able girls do not want college immediately upon high school graduation, but do want nursing; some able girls are strongly attached to the hospital environment, and will not be deterred by any other form of education; some have a need to work early, and this need far outweighs the fact that a collegiate program in the long run may be more economical of time and sounder in educational planning. They are looking for good programs to fit their needs. With few exceptions, they are not conscious of the status attached to the chosen school. They look for "goodness" and with "goodness" in their eyes comes a very special status. Professional status can be emphasized by the profession. It can become a kind of aura covering the chosen ones. The fact that a nurse walks in this aura does not make her professional in stature. Such stature is earned through the

application of sound knowledge applied skillfully in the care of patients. No one can award this stature. It must be earned. The earner may not bear the title "professional" but this stature will bring honor, respect, opportunity to work successfully in a chosen field, and life-long satisfaction. It will also bring to the school which produces such nurses candidates of good quality and similar interests.

And the profession? What is it to say? A profession has of course many voices. Some here call for more nurses. Most in the profession speak for the education they had, or perhaps the one they have come to know in their own daily work. Seldom can all in the profession with different ideas or different philosophies speak together with understanding. Many are too confused.

I am reminded of the story in Genesis "And the whole earth was of one language and one speech and they said 'Go to, let us build us a city, and a tower, whose top may reach unto heaven . . .'"

"And the lord came down to see the city and the tower, which the children of men builded. And the Lord said, 'Behold, the people is one, and they have all one language; and this they begin to do; and now nothing will be restrained from them, which they imagined to do. Go to, let us go down and there confound their language, that they may not understand each other's speech.' So the Lord scattered them abroad from thence upon the face of the earth: and they left off to build the city."¹

"that they may not understand each other's speech and they left off to build the city."²

1 The Dartmouth Bible; Genesis II, Houghton Mifflin Co., Boston, 1950

2 Ibid

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Surely we as nurses do not understand each other any better than the people of Babel. So we are divided. We differ in philosophies and prejudices, in ignorance. Lack of ability to communicate prevents us too from learning what others are doing and why. We differ in our own backgrounds, and we lean on so-called values to avoid facing new ideas which challenge our thinking or old ideas too good to be discarded. We have built our cities around our own interests and our own understandings, and we fear the threat inherent in strange new patterns of education, or in the solid values of the old.

Now, why are we in hospitals concerned about the orientation of graduates from all three forms of basic programs for nursing? Graduates from all three patterns have the same goal - patient care. One group of graduates because of the philosophy underlying its program comes with a reasonable supply of practical knowledge with more mechanical skill, and with a degree of judgment tested in repetitive patient care. A second group, again because of the philosophy underlying its program, comes with almost a minimum of mechanical skill but with a strong emphasis on understanding people and a body of theory soundly selected and readily usable. A third group, because of the differing philosophy and aim of its program, brings a broader knowledge of nursing: an understanding and readiness to develop skill; a breadth of learning which stimulates its graduates to question, to challenge, to speak; a group ready to think for itself and, when prepared, to lead. Now I am not saying that leaders are not found among three-year graduates or two-year graduates. ⁴⁻³ So close are past and present we find many, perhaps most, of today's leaders are products of three-year schools, but not necessarily leaders because of what the school did to them or for them.)

[illegible]

How does a Nursing Service deal with the in-service education program for a group including two-year, three-year, and four-year graduates? We might also include one-year graduates in this list, for much of the orientation can be given to the nursing team as a whole. This does not seem difficult, approached in terms first of the new factors in the situation which all need to learn - some general factors needed by all; some specific nursing knowledge which all nurses will need. From this point of orientation forward, the program would be planned in terms of individual differences as your programs must now be planned. For example, in my situation we must make different allowances for our own new graduates, familiar with our patient care units, for new graduates of schools in hospitals similar to our own, from those we make for new graduates from small, non-teaching hospitals, for old graduates returning to nursing after an absence of fifteen to twenty years, and for the nurse coming as an Exchange Visitor from abroad. Surely there would be in a group composed of two, three and four-year graduates a more common basis for planning the continuing in-service education program than we find in our program today.

I am often asked: "Is it right for the hospital to spend so much on in-service education for these two and four-year graduates who need time to develop their skills?" I can only reply that in-service education is the responsibility of every employing agency which desires a strong and progressive patient care program, and every teaching program to be successful must be developed not only to meet the needs of the individuals but also to provide that opportunity for each individual to develop her own capacities and abilities to the maximum. Each graduate brings certain values. Is it not worth while for your hospital and health agency and mine to secure the greatest possible return by giving the most appropriate opportunities? #4

In the final decision we should help the three-year graduate to find satisfactions in her skill, and to gain more knowledge; the two-year graduate to find challenge in gaining skill and satisfactions in the use of her knowledge; the four-year graduate to grow in skill and find satisfactions in the growing ability to solve nursing problems and to take leadership. Surely we can integrate these young women, and gain strength in our nursing services because of the diversity of the members.

I believe in Nursing Education. I believe in the school conducted by the hospital. I believe this is no time to decrease the number of graduates. The need multiplies. The aged group in our society will increase from 15.4 million to 24.5 by 1980, less than twenty years away. The children under five will also increase from 20 millions to 32 millions in this time. In ten years the under twenty years of age group will equal 43% of our population. You will draw your own conclusions as to need.

Who is to say what nurse educators in three-year schools can do, or should do? You hear the comments about our schools over and over again. (We do not need to be apologetic or ashamed because we help to conduct diploma programs in our hospital. We do need to be apologetic when we conduct weak schools, when we graduate nurses inadequate to the patients' needs and the evolving patterns of patient care which demand more and more knowledge. As directors of schools it is our responsibility to see the needs in our own situations, to know the broad plan for nursing education, honestly to provide opportunity for sound learning, to see that students are stimulated to use this opportunity, and to interpret this plan wherever we can. Hospital administrators who want nurses for direct patient care must support goodness in their schools, morally, administratively, financially.) Members of the advisory councils must study the over-all problems of nursing education and, when appropriate in facility

In the first instance, the whole of the country was

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planning, seek assistance for the school through channels open perhaps only to them as members of other community groups. I include no comment on the responsibility of the medical staff, since doubtless none are here to participate in the meeting, but they too have a supporting role and a teaching role, both of which are often of little value because the medical man fails to see the relationship of quality education to the quality of care given by the graduate nurse.

Who is to say what shall happen to the three-year hospital school? Quality in program will stimulate it. Mediocrity will close it. The hospital school is not a misfit in our educational society just because there is no parallel in other educational fields. The hospital school is not necessarily an outworn educational pattern because other forms of programs have been introduced. It can stand as a source of nurse supply if we as nurses will guide it, improve it, enrich it, make the graduates proud of it. But, who is to say?

Who is to say what should happen to the three-year schools. There are at least 3 alternatives, keep as is or close, or modify to improve the program and product. The choice could be made to secure status for the graduates - some might say. The choice could be made on the basis of expense to hospital or ultimately the patient. The choice could be made because those who conduct the schools see a nation-wide growing community need and a possible disaster from lack of prepared nurses in the country hospitals. I am not well enough to choose the latter and meanwhile I hope 2 + 4 year programs will grow in quality and enrollment. I hope the three year schools will improve so that 10-20-30 year programs will be the next appropriate step can be taken by public health programs merit educational consideration. I hope also that medical care organizations such as this one will help in the public education.

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WHO IS TO SAY?

WHO IS TO SAY?

by

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Vermont League for Nursing
Stowe, May 24, 1962

WHO IS TO SAY?

Three suggestions were made for my discussion with you today: first, the position of the three-year graduate, is she threatened by the growing number of two-year or junior college graduates, and the status given by some to the graduate of the four-year baccalaureate program; second, how do we orient this group of nurses who come to our hospitals and health agencies with such different educational backgrounds; and third, what is the future of the three-year hospital-controlled school.

Actually all three questions are related, the status of the three-year graduate, her ability to compete in the world of nurse employment, and judging by its value, should the three-year school which prepares these graduates continue. Lest there be some misunderstanding as I speak, let me say first I stand for the best in nursing education. I believe in the worth of, and the need for, the good three-year school. I encourage the further development of good nursing programs in the junior college. I want to see the colleges and universities graduate an increasing number of the best possible nurses who are also educated women. In short, I stand for nursing education of all types. But I will take this stand only if the programs are of high quality. It is not the length of a program which makes a nurse. It is the soundness of the plan, the quality of the teaching, the attendant degree of learning, the resultant attitudes of the product toward her responsibilities. Be the program a two-three-four or five-year program it can either meet or fail to meet these standards. It is not to the length of a program to which we should look for the measure of "goodness."

Who is to say how nurses are to be educated? Shall we listen to the consumer? What will the consumer of nursing services want: the doctor, the hospital administrator, the director of nursing service, the health officer in the community? What does the doctor want? He sees the lack of patient care; he sees orders inadequately carried out, and treatments become ineffective. Will he speak only for that plan which increases the number of nurses? Does he stop to question educational background? Does he realize what the graduates of the three programs are prepared to do?

The hospital administrator too has spoken. He has worried about closed beds and the implications of the situation have involved us all. He has urged increased enrollment in "his" schools, and his demands have exceeded our abilities. He has disagreed, sympathized, hindered, applied pressure, he has helped. What does he want? Is it numbers? He knows the trends in institutional care. He studies the needs of his community, as does the health officer who sees the shortages in his service too.

The director of nursing service may approach the situation differently, but her problem is not dissimilar. She has stretched the nurses as best she can, but there are not enough. She knows where the practical nurse can replace the nurse. She knows how much responsibility the aide should be given. She knows the unsafe factors in her service. What does she want? Quality nursing is her goal, but numbers of nurses, numbers of nurses to cover the need may be her conscience's first demand.

The patient, what does he say? Who would you choose to help you with the acts of daily living if you were too weak, too handicapped physically

and emotionally to carry on alone? If you were very ill indeed, and a patient in a hospital ward, would you feel secure at night with just anyone? Would it make a difference if the only nurse you saw during the night went only to those patients who needed injections and so she passed you by? Would the shortness of breath grow more frightening? Would you worry about tomorrow's operation? Would you have faith that others in the ward would keep the tracheostomy tube clear and replenish the oxygen supply? What will the patient say is needed? Numbers, procedural care, or "insightful" care, combined with knowledge of people and their needs. Who does the patient want, a two or three or four-year graduate?

What of the young women and young men, the nurses of the future? They want to be heard too. Look at them. They vary in ambition, interests, ability, time, money. Their common goal is to help people. Must they all be placed in one mold? They are not interested in numbers as they plan their futures. They may not comprehend the term "quality care" in nursing. Let us be honest and courageous enough to admit these differences, and plan accordingly: some girls and boys see for themselves special values in a college education; all girls and boys cannot afford a college education; some able girls do not want college immediately upon high school graduation, but do want nursing; some able girls are strongly attached to the hospital environment, and will not be deterred by any other form of education; some have a need to work early, and this need far outweighs the fact that a collegiate program in the long run may be more economical of time and sounder in educational planning. They are looking for good programs to fit their needs. With few exceptions, they are not conscious of the status attached to the chosen school. They look for "goodness" and with "goodness" in their eyes comes a very special status. Professional status can be emphasized by the profession. It can become a kind of aura covering the chosen ones. The fact that a nurse walks in this aura does not make her professional in stature. Such stature is earned through the

application of sound knowledge applied skillfully in the care of patients. No one can award this stature. It must be earned. The earner may not bear the title "professional" but this stature will bring honor, respect, opportunity to work successfully in a chosen field, and life-long satisfaction. It will also bring to the school which produces such nurses candidates of good quality and similar interests.

And the profession? What is it to say? A profession has of course many voices. Some here call for more nurses. Most in the profession speak for the education they had, or perhaps the one they have come to know in their own daily work. Seldom can all in the profession with different ideas or different philosophies speak together with understanding. Many are too confused.

I am reminded of the story in Genesis "And the whole earth was of one language and one speech and they said 'Go to, let us build us a city, and a tower, whose top may reach unto heaven . . .' "

"And the lord came down to see the city and the tower, which the children of men builded. And the Lord said, 'Behold, the people is one, and they have all one language; and this they begin to do; and now nothing will be restrained from them, which they imagined to do. Go to, let us go down and there confound their language, that they may not understand each other's speech.' So the Lord scattered them abroad from thence upon the face of the earth: and they left off to build the city."¹

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1 The Dartmouth Bible; Genesis II, Houghton Mifflin Co., Boston, 1950

2 Ibid

Surely we as nurses do not understand each other any better than the people of Babel. So we are divided. We differ in philosophies and prejudices, in ignorance. Lack of ability to communicate prevents us too from learning what others are doing and why. We differ in our own backgrounds, and we lean on so-called values to avoid facing new ideas which challenge our thinking or old ideas too good to be discarded. We have built our cities around our own interests and our own understandings, and we fear the threat inherent in strange new patterns of education, or in the solid values of the old.

Now, why are we in hospitals concerned about the orientation of graduates from all three forms of basic programs for nursing? Graduates from all three patterns have the same goal - patient care. One group of graduates because of the philosophy underlying its program comes with a reasonable supply of practical knowledge with more mechanical skill, and with a degree of judgment tested in repetitive patient care. A second group, again because of the philosophy underlying its program, comes with almost a minimum of mechanical skill but with a strong emphasis on understanding people and a body of theory soundly selected and readily usable. A third group, because of the differing philosophy and aim of its program, brings a broader knowledge of nursing: an understanding and readiness to develop skill; a breadth of learning which stimulates its graduates to question, to challenge, to speak; a group ready to think for itself and, when prepared, to lead. Now I am not saying that leaders are not found among three-year graduates or two-year graduates. So close are past and present we find many, perhaps most, of today's leaders are products of three-year schools, but not necessarily leaders because of what the school did to them or for them.

How does a Nursing Service deal with the in-service education program for a group including two-year, three-year, and four-year graduates? We might also include one-year graduates in this list, for much of the orientation can be given to the nursing team as a whole. This does not seem difficult, approached in terms first of the new factors in the situation which all need to learn - some general factors needed by all; some specific nursing knowledge which all nurses will need. From this point of orientation forward, the program would be planned in terms of individual differences as your programs must now be planned. For example, in my situation we must make different allowances for our own new graduates, familiar with our patient care units, for new graduates of schools in hospitals similar to our own, from those we make for new graduates from small, non-teaching hospitals, for old graduates returning to nursing after an absence of fifteen to twenty years, and for the nurse coming as an Exchange Visitor from abroad. Surely there would be in a group composed of two, three and four-year graduates a more common basis for planning the continuing in-service education program than we find in our program today.

I am often asked: "Is it right for the hospital to spend so much on in-service education for these two and four-year graduates who need time to develop their skills?" I can only reply that in-service education is the responsibility of every employing agency which desires a strong and progressive patient care program, and every teaching program to be successful must be developed not only to meet the needs of the individuals but also to provide that opportunity for each individual to develop her own capacities and abilities to the maximum. Each graduate brings certain values. Is it not worth while for your hospital and health agency and mine to secure the greatest possible return by giving the most appropriate opportunities? goodness in their schools, usually, which creatively, financially. Members of the advisory councils must study the over-all problems of nursing education and, when appropriate in facility

In the final decision we should help the three-year graduate to find satisfactions in her skill, and to gain more knowledge; the two-year graduate to find challenge in gaining skill and satisfactions in the use of her knowledge; the four-year graduate to grow in skill and find satisfactions in the growing ability to solve nursing problems and to take leadership. Surely we can integrate these young women, and gain strength in our nursing services because of the diversity of the members.

I believe in Nursing Education. I believe in the school conducted by the hospital. I believe this is no time to decrease the number of graduates. The need multiplies. The aged group in our society will increase from 15.4 million to 24.5 by 1980, less than twenty years away. The children under five will also increase from 20 millions to 32 millions in this time. In ten years the under twenty years of age group will equal 43% of our population. You will draw your own conclusions as to need.

Who is to say what nurse educators in three-year schools can do, or should do? You hear the comments about our schools over and over again. We do not need to be apologetic or ashamed because we help to conduct diploma programs in our hospital. We do need to be apologetic when we conduct weak schools, when we graduate nurses inadequate to the patients' needs and the evolving patterns of patient care which demand more and more knowledge. As directors of schools it is our responsibility to see the needs in our own situations, to know the broad plan for nursing education, honestly to provide opportunity for sound learning, to see that students are stimulated to use this opportunity, and to interpret this plan wherever we can. Hospital administrators who want nurses for direct patient care must support goodness in their schools, morally, administratively, financially. Members of the advisory councils must study the over-all problems of nursing education and, when appropriate in facility

planning, seek assistance for the school through channels open perhaps only to them as members of other community groups. I include no comment on the responsibility of the medical staff, since doubtless none are here to participate in the meeting, but they too have a supporting role and a teaching role, both of which are often of little value because the medical man fails to see the relationship of quality education to the quality of care given by the graduate nurse.

Who is to say what shall happen to the three-year hospital school? Quality in program will stimulate it. Mediocrity will close it. The hospital school is not a misfit in our educational society just because there is no parallel in other educational fields. The hospital school is not necessarily an outworn educational pattern because other forms of programs have been introduced. It can stand as a source of nurse supply if we as nurses will guide it, improve it, enrich it, make the graduates proud of it. But, who is to say?

make the decisions for all Nursing?

Long before 1952, the natal year of the National League for Nursing saw the beginning of a new approach to these questions. Nursing, a new and radical decision was slowly being shaped. There were two lessons from Nursing in the First World War had not been forgotten then six National Nursing Organizations developed over a period of six decades in which professional nursing had grown to play an increasingly important national role. To cope with the nursing needs of the country during war time, to protect the education of the country's future nurses required pre-planning. There were the National League of Nursing Education¹, organized in 1893; the American Nurses Association² in 1897; before Pearl Harbor. All our war-time programs necessitated coordinated action. The National Association of Colored Graduate Nurses in 1908; the National Organization of Public Health Nurses in 1912; the Association of Collegiate Schools of Nursing in 1935; and the American Association of Industrial Nurses in 1942. This Council included all six National Nursing Organizations, the first two were conceived to meet broad needs of nurses and nursing education. The latter four developed each in turn to meet a specialized need believed unattainable through either of the earlier professional associations and the Public organizations.

It became obvious quickly after the early days of the war that the implications implicit in the names of the organizations Organized Nursing must also be ready for peace. How could the six organizations indicate the wide diversity of problems which faced the growing profession. How could the great thrust which would inevitably come as the nation returned to normalcy? How could Nursing be organized to carry forward most effectively? There was in the aggregate a unity which showed in joint meetings and joint decisions. When, however, an allied professional organization sought information on nursing, or a public statement was to be made, there was no indicated, a coordinated plan. The National Nursing Planning Committee had representation from the six National Professional Organizations and six voices to make the announcement. Nurses themselves were uncertain and the National Association for Practical Nurse Education. In the summer of 1945, just before the war's end "A Comprehensive Plan for Nation-Wide Action in the Field of Nursing" was ready for Nursing and for the Public.

National Organization of Public Health Nurses and the Association of Industrial Nurses

- 1 First organized as the American Society of Superintendents of Training Schools.
- 2 Named first the National Associated Alumnae of the United States and Canada in 1897

NATIONAL LEAGUE FOR NURSING

Long before 1922, the natal year of the National League for Nursing, a new and radical decision was slowly being shaped. There were then six National Nursing Organizations developed over a period of six decades in which professional nursing had grown to play an increasingly important national role. There were the National League of Nursing Education, organized in 1893; the American Nurses Association, in 1897; the National Association of Colored Graduate Nurses in 1908; the National Organization of Public Health Nurses in 1912; the Association of College Schools of Nursing in 1922; and the American Association of Industrial Nurses in 1942. The first two were conceived to meet broad needs of nurses and nursing education. The latter four developed each in turn to meet a specialized need believed unattainable through either of the earlier organizations.

The implications implicit in the names of the organizations indicate the wide diversity of problems which faced the growing profession. Titles may indicate also a diversity of interests. And such a diversity did exist. There was in the aggregate a unity which showed in joint meetings and joint decisions. When, however, an allied professional organization sought information on nursing or a public statement was to be made, there were six boards of directors to make the decision, six policies to be cleared, and six voices to make the announcement. Nurses themselves were uncertain where to look for firm guidance on broad questions of policy. The public, and especially allied professional groups, were confused.

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Who will, or who should speak for all Nurses? Who was to make the decisions for all Nursing?

1941 saw the beginning of a new approach to these questions.

The lessons from Nursing in the First World War had not been forgotten by the leaders in Nursing. To cope with the nursing needs of the country during war time, to protect the education of the country's future nurses required pre-planning. Nursing was in fact partially organized before Pearl Harbor. All out war-time programs necessitated coordinated action. These needs were met. The National Nursing Council for War Service was brought into being to coordinate the efforts of Organized Nursing. This Council included all six National Nursing Organizations, the National Association for Practical Nurse Education, representatives from the military and non-military governmental nursing agencies, the Red Cross, allied professional associations and the Public.

It became obvious quickly after the early days of the war that Organized Nursing must also be ready for peace. How could the six organizations meet the great thrust which would inevitably come as the nation returned to normalcy? How could Nursing be organized to carry forward most effectively? What should be planned for future action? Obviously, goals should be delineated before organizational changes could be considered. A plan for action of Organized Nursing was indicated, a coordinated plan. The National Nursing Planning Committee had representation from the six National Professional Organizations and the National Association for Practical Nurse Education. In the summer of 1945, just before the war's end "A Comprehensive Plan for Nation-Wide Action in the Field of Nursing" was ready for Nursing and for the Public.

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The profession could now consider the organizational structure needed to bring the plan to fruition. Again there was concerted action as the Committee to consider the structure of Organized Nursing began its study. Not only did the officers of the participating organizations have a voice in the planning and the decision, but eager nurses throughout the nation read the articles in the American Journal of Nursing and Public Health Nursing. Questionnaires and opiniennaires were circulated. State and district organizations provided forums for discussion. For a moment interests were merged. Sights were focussed on common goals. The enormity of the task and the importance of the outcome directed and absorbed individual and organizational concerns. To some the proposed structure itself was the key to future progress and the development of programs hoped for. To others the structure was less important, a means only of achieving the desired nursing for a growing population. Still other members saw in a new structure strength for the educational programs needed for the Profession.

The decision was made, agreements were written, and the final votes cast in June, 1952 at the last biennial convention of the American Nurses Association, the National League of Nursing Education and the National Organization of Public Health Nurses. The American Nurses Association remained as the professional organization of nurses. The National Association of Colored Graduate Nurses, no longer needed, because its program was at last rightly to be carried by the American Nurses Association and the new organization, had dissolved 15 months before. The American Association of Industrial Nurses chose to continue as an independent organization to meet the specialized needs of industrial nurses. The National League of Nursing Education, the National Organization of Public Health Nurses and the Association of Collegiate

Schools of Nursing merged by common consent into the new organization. The National League for Nursing, born that the "Nursing needs of people may be met," was geared through sound structure and flexible program to meet and change with social change. Its sights were set for Nursing. Its membership coordinated all groups who contribute to nursing be they nurses or non-nurses, all groups who use the nursing services be they members of allied professions or citizens, and all interested and concerned for the future advancement of education for nursing.

Years of working. Years of planning. Years to learn that a decision must be faced. If Nursing were to be ready to meet the challenge of the last half of the twentieth century there must be understanding and unity of purpose and program for those concerned with nursing services. If Nursing were to take its full responsibility for the nation's health, there must be a coordinated plan for the continuing preparation of all required to fulfill this obligation.

It has been said "There is never a last step, but only one more step. Nothing is ever over; it is all a continuing process." The decision of 1952 was radical. It was made by women of foresight and courage. It was just one step taken out of an illustrious past into a challenging future. Through this step a new pattern of action was established, a new flexibility and breadth in program planning was achieved. The inescapable decision was made.

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MESSAGE IN NURSING

Some of you in this audience this morning may have wondered why
Barney or why a Nurse was included in a panel on Research. In fact there
are those in every community who continue to see nursing as a supplementary
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RESEARCH IN NURSING

RUTH SLEEPER, R.N., formerly at the position of

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CONFERENCE

- City of Boston

NOVEMBER 8, 1962

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with adequacy of nursing care and nursing service in terms of content, organization,
and availability; the second concerned with improving quality of care through
advancing knowledge of science applied in nursing care.

In hospitals it has long been customary for nurses to play a part in some
research projects conducted by the medical staff, but the nurse's role was often
not recognized although her contribution was vitally as vital both to the success
of the research and the welfare of the patient studied. Today the nurse's role
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RESEARCH IN NURSING

Some of you in this audience this morning may have wondered why Nursing or why a Nurse was included in a panel on Research. In fact there are those in every community who continue to see Nursing as a complementary service to Medicine, taking its direction from the doctor, and carrying out only those procedures ordered by the doctor. To be sure, not many years ago there would have been no reason to include nurses in a discussion on research, for nurses themselves had not begun to look critically at the practice of Nursing or at the needs existing within this field.

Nursing as a profession has moved rapidly in the last ten years to take its place with other groups within the health field. Nursing continues of course to work with Medicine in the care of the patient. This constitutes an important segment of nursing practice. But Nursing today also carries some independent functions essential for the welfare of the sick.

Studies and research in Nursing have taken two directions, one concerned with adequacy of nursing care and nursing service in terms of amount, organization, and availability; the second concerned with improving quality of care through advancing knowledge of science applied to nursing care.

In hospitals it has long been customary for nurses to play a part in some research projects conducted by the medical staff, but the nurse's role was often not recognized although her contribution was vitally essential both to the success of the research and the welfare of the patient studied. Today the nurse's role is changing. She works as a member of the research team with doctors, biologists, sociologists and others. Or, the nurse may lead a research team. Or, she may carry on independent research.

Hospital Nurses, though seldom prepared to conduct research, are faced constantly with the problems of patient care which demand study. The need for nurses in Boston hospitals, nursing homes and health agencies far exceeds the number that our 12 schools of nursing and 4 schools of practical nursing can presently supply. (I speak now only of those within the limits of the Boston jurisdiction.) Moreover all evidence points to a continuing shortage. The number of patients needing care increases, the complexity of the medical program adds more tests, more highly technical treatments, the radical quality of the surgery grows, the pace of care accelerates. It is said that today in teaching hospitals an average of 23¹ tests per patient day are done, and that therapy has risen 400% in contrast to 1948. As a result of these pressures nurses in hospitals tend to focus their studies on methods of preparing personnel, devices to save nursing time, and studies of organization which will result in better utilization of the many different types of personnel employed in nursing. A look at the nursing staff of a teaching hospital as well as non-teaching will show newcomers to the nursing staff. These include the nurse method's analyst and the management engineer. Studies concerned with volume of medications administered, methods of administration, etc. are done. Such studies though simple take on considerable significance when a hospital staff finds 1,500 medications administered on six patient units in a 24-hour period, or that 41 patients on one day received 350 doses of medicine.

The nurse who formerly worked alone at the bedside is today only one of several. How to prepare some of these workers, how to organize and supervise, how to evolve safe and adequate patterns of care, how to reassure the patient who many days must adjust 60-70 times to someone coming to the bedside or entering his room - be it to clean, take blood sample, do a dressing,

1 "What the Doctor Can't Order But You Can," Tane Report, 1961

Boston is fortunate in possessing three institutions of higher learning in which there are well established Schools of Nursing, with nurses prepared to give leadership in the field of research. These institutions are Boston College, Boston University, and Simmons College. The University School sponsored projects are truly research centered, are sometimes supported by grants which provide prepared workers with time to carry on the necessary investigations. The subjects studied cover a wide range of problems. Boston College School of Nursing in one area of its program is conducting a three-year study of nursing homes "To develop a method of determining the needs of nursing home patients, in order to provide a sound basis for planning and implementing adequate nursing care." Boston University School of Nursing lists many studies which have been or are concerned with problems close to all interested in human welfare. Some of these problems deal with aspects of the health needs of the elderly person living alone; mother and child relationships; chronic disease; the needs of the mother giving birth to a handicapped child; and the mentally handicapped. Findings of studies on Nursing in the Out-Patient Department in selected Boston Hospitals were recently published by Boston University Human Relations Center. One of the major research activities in which the Simmons College School of Nursing is presently involved is a Nursing Career Pattern Study, sponsored by the Research and Studies Service of the National League for Nursing.

At the Massachusetts Memorial Hospitals the Nursing Service is now cooperating with Boston University School of Nursing in two areas of investigation: one dealing with preparation of personnel who contact the patient; the other with the use of the hospital nurse in psychiatric follow-up care.

or bathe, feed, or medicate. This is no small problem to study. Is it any wonder the Nursing staff welcomes the methods analysts and the management engineers?

Mechanical devices are also appearing. How many of these the Boston Hospitals will use effectively to save the nurses' time for patient care is still a question. They range from machines to take vital signs, blood pressure, pulse, respiration, to machines dispensing medicines according to specified doses, to computers. In one institution Nursing has now the privilege of sharing in a research team studying the possible usefulness of the computer in nursing care. It is far too early to predict whether we shall find only another important means for nursing research, or whether we shall also have a new and still immeasurably valuable mechanical partner in nursing care and nursing services.

We do know that only as we can study and adapt the new devices, only as we can organize for more effective use of all categories of workers in our institutions and agencies, can we meet the health needs of the people sick and well in our City.

1-120:1 D13-15c Superintendent of Nurses

1 School of Nursing

